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ORIGINAL DEPARTMENT.

LECTURE.

CIRRHOSIS OF THE LIVER, WITH HYPERTROPHY.

Clinical Lecture delivered at La Charité,

BY M. HARDY,

Professor of Clinical Medicine in the Paris Faculty.

Translated for the MEDICAL AND SURGICAL REPORTER.

GENTLEMEN:—Cirrhosis of the liver with hypertrophy has been recognized as a distinct morbid entity only within the past few years. Up to this period it has been confounded with chronic hepatitis and with ordinary cirrhosis. An attentive consideration of the observations of authors who, twenty years since, devoted especial attention to diseases of the liver, will demonstrate that many of the cases, both by the symptoms observed during life, as also by the lesions revealed at the autopsy, appertained manifestly to the category of cases of cirrhosis with hypertrophy.

I desire particularly to recall three cases mentioned in the clinical lectures of Andral, where the patients presented, in conjunction with gastric troubles, a remarkable augmentation in volume of the liver, with jaundice, and at the autopsy all the lesions characteristic of hypertrophic cirrhosis. Nevertheless, at this period it was already remarked that in certain patients who presented all the ordinary symptoms of cirrhosis, the liver, instead of being atrophied, was augmented in volume. To explain this it was said that in the first period of cirrhosis the liver was hypertrophied, but became gradually contracted or atrophied at a more advanced period of the disease.

In 1852, M. Gubler, in his aggregation thesis on jaundice, signalized, and he was among the first to draw attention to the subject, a peculiar form of cirrhosis, in which the liver, instead of being contracted, was either augmented in volume or of the normal size. He concluded that this constituted a special variety of the affection.

This supposition had before this been considered by Requin, who, having observed two cases of cirrhosis with an enlarged liver, believed that this effect was proper to an unknown form of the disease. But we must arrive at a much more recent date, viz: 1871, before finding more complete information on the subject. At this period, in effect, after the relation of a similar observation by M. Paul Ollivier, a disease of the liver was described which differed from ordinary cirrhosis by the symptoms and anatomical lesions, and for the first time it was concluded that cirrhosis with hypertrophy was a different affection, constituting a special disease; that it was, in fact, a distinct morbid entity.

From this moment many new cases were reported. M. Hayem observed three cases of cirrhosis, characterized by augmentation in the volume of the liver and jaundice, and at the autopsy by special lesions. Then came the works of M. Charcot and M. Luys on the pathological anatomy of this affection, and finally M. Cornil's work; and it is to him is due the merit of having established that the lesions special to hypertrophic cirrhosis consist particularly in the augmentation in volume of the biliary canaliculi, resulting from the proliferation of the epithelial cells which line the internal walls of these tubes; this condition of things induces consecutively retention of bile in them. From this period a special form of hepatic alteration was admitted, to which the designation hypertrophic cirrhosis was applied.

All these details regarding the history of the malady, the pathological anatomy and the symptoms, are very well described in an excellent work by M. Hanot, who, in 1876, published a very remarkable thesis on hypertrophic cirrhosis, in which he collected a great number of observations from different authors, adding several which he had himself observed.

As regards the history of the disease, three periods may be established: at first hypertrophic cirrhosis is absolutely confounded with ordinary cirrhosis; in the second period it is remarked that the liver, instead of becoming contracted, as usual, may be enlarged, but there is no attempt made to establish a distinction between the two forms; finally it is admitted that hypertrophic cirrhosis is an entirely different disease, having its peculiar symptoms and special lesions. It might be said, even, that we are to-day at the beginning of a fourth period.

And in effect, although through the labors of MM. Ollivier, Hayem and Cornil, it has been possible to separate atrophic cirrhosis from hypertrophic cirrhosis, it has yet been found that in a certain number of cases symptoms proper to both are found in the same individual, and that finally the alterations common to both affections supervene. Whence it has been concluded that, though in certain cases atrophic cirrhosis or hypertrophic cirrhosis may be observed with perfectly distinct characteristics, symptoms, etc., yet in many cases these two varieties of cirrhosis are associated, so that there is a mixed form, characterized by the anatomical lesions and symptoms belonging to both forms. Such cases are even frequent. We had such a case in our wards last year; the patient had jaundice and ascites; at the autopsy the lesions of atrophic cirrhosis were found coexistent with those characteristic of the hypertrophic form of disease. Finally, as recently as last week, you have remarked the patient who occupied the No. 5 bed in the St. Charles ward, who presented also, as prominent symptoms, jaundice and ascites, while at the post-mortem the lesions proper to both affections were found.

If, then, pathologically speaking, these are two distinct and separate diseases, clinically such is not always the case; they are often combined and associated together, making a mixed form. In such cases the liver has its normal volume or may become somewhat enlarged; it never becomes so contracted as in simple atrophy. In these cases, through the influence of the hypertrophic cirrhosis, there is a tendency to enlargement, but the coexistent atrophy tending at the same time towards contraction, the organ remains almost of the normal size, and at the autopsy is found to be neither enlarged nor contracted.

The symptoms proper to the hypertrophic form of cirrhosis at the début of the disease differ from those observed later on. In the beginning the patient may suffer from gastro intestinal troubles. There is notable diminution of the appetite, digestion is difficult, frequently vomiting is complained of, sometimes diarrhœa supervenes. Such were the primary symptoms observed in one of our recent cases. During the eight months he passed in the service you have been able to observe the frequent emesis and the diarrhœa from which he suffered. At this primary period, also, there is very frequently pain, not only in the part of the abdomen corresponding to the liver, but also in the left hypochondrium and epigastric region. These gastric derangements soon enfeeble the patient, causing him to lose flesh and strength. Later on and among the first phenomena of the second stage of the affection, jaundice supervenes, and this, with the enlargement of the liver, is the most marked sign of hypertrophic cirrhosis. It may even be said that jaundice holds the same relation to this form as ascites does to the atrophic form of the disease. Not only the jaundice is intense, it is also persistent. So that certain patients, who have lived five or six years, never were completely clear of this yellowish coloration of the skin, which, though more marked at certain periods, and sometimes completely disappearing for a time, almost always remained persistent, and in some cases was permanent.

In connection with this well marked sign, there is another which, with the pain in the right hypochondrium, of which I have spoken, early attracts the patient's attention. This is an enlargement at the upper part of the abdomen, which prevents the patient from buttoning his garments as usual. And, in effect, there exists there a veritable tumor, and when the abdomen is examined by palpation, a notable resistance is found in the right hypochondrium, which indicates that the liver is augmented in volume.

In order to well appreciate this enlargement of the liver by percussion, it is well to commence above and proceed downward, beginning directly beneath the axilla, so as to determine the extent of transversal dullness.

Not only the liver is augmented in volume; it is found also that the spleen has undergone considerable enlargement, much more marked than in the atrophic form of the disease; at the same time there is considerable pain on pressure over the organ. In certain cases this splenic enlargemen

is so marked that it is impossible to determine, by percussion, where the dullness due to the spleen ends and that to the liver commences, in the epigastric region. But in the course of the disease the patient frequently suffers from intense pain over these organs, and also frequently over other portions of the abdomen. These painful symptoms are explained by the pathological anatomy which demonstrates the existence of localized inflammation, either of the peritoneum covering the liver or spleen, or even of that portion of the serous membrane which is spread like a veil before the intestines. It was this chronic inflammation of the peritoneum which induced the vague pains in the side of the abdomen complained of by the patient of whom I have recently spoken.

At the same time certain negative symptoms are observed, which aid in establishing the diagnosis between the two forms of cirrhosis. Thus, if the superficial abdominal veins are not prominent at the surface of the skin, and are not distended, it may, thence, be concluded that the circulation in the liver is free, that the hepatic veins are not compressed, that the portal system is intact and performs its functions, that consequently there is no necessity for the blood to pass by the collateral veins to reach the heart; in a word, it may be assumed that the case is one of hypertrophic cirrhosis.

But it must be said, also, that this dilatation of the subcutaneous abdominal veins is frequently observed in hypertrophic cirrhosis. M. Hanot reports in his thesis several observations of this kind, and our own patient was an example. It would seem, however, that this negative phenomenon, the absence of venous dilatation, which has been considered as one of the characteristics of hypertrophic cirrhosis, has not its *raison d'etre*. When such does exist, it is generally the mixed form of cirrhosis, in which the two forms coexist in the same individual, that is present. It is in effect in these mixed forms that, with a liver of the normal size and with jaundice of more or less intensity, exaggerated development of the pre-abdominal and hemorrhoidal veins, and all the signs of difficulty of the hepatic circulation, finally supervene.

Another negative phenomenon of the highest importance is the absence of ascites. But if ascites does not exist ordinarily in true hypertrophic cirrhosis, M. Hanot has nevertheless cited cases where patients presenting all the characteristic signs of this affection had a considerable effusion of liquid in the peritoneal cavity. Our patient, as also the one observed last year, was in the same category. This sign, then, has not, any more than the dilatation of the abdominal veins, the absolute value ordinarily attributed to it. Yes, certainly, ascites is not present in simple, uncomplicated, hypertrophic cirrhosis; but there are many cases where the symptoms of both forms are found united, and in which are observed at the same time jaundice, ascites and dilatation of the pre-abdominal and hemorrhoidal veins.

I would add that the urine, in this malady, presents all the physical and chemical modifications usually observed in patients with jaundice. Thus, it is voided in greater quantity than in atrophic cirrhosis; it has a dark yellow coloration which has no resemblance to the hortensia red tinge, due to the presence of urates and urohæmatin, of the urine of patients in the atrophic form. On the contrary, in this form of the disease there is often a marked diminution in the quantity of urea; sometimes but four or six grams are excreted in twenty-four hours, instead of twelve or sixteen grams, the usual quantity excreted in the normal state of the system.

Patients in hypertrophic cirrhosis are subject to hemorrhages from the nose, the skin, the mouth, etc.; these symptoms are due to the jaundice and not to the hepatic lesion itself. It will be observed that these individuals, subject to hemorrhages during the period that they have the yellowish tinge communicated by the bile to the integuments, cease to suffer from them when the jaundice itself disappears.

Independently of the local phenomena which I have described, there also exist in this malady various constitutional symptoms. Thus, after a period, though sometimes from the début of the malady, there supervenes a disgust for food, anorexia, vomiting, diarrhœa, and finally, through want of nourishment, loss of flesh and general feebleness. Finally, after a variable period, supervene all the phenomena of cachexia, which demonstrate the effect of the disease on the general health.

On the other hand, the jaundice, when it is intense and persists for a lengthened period, presents all the symptoms observed with this morbid condition, that is, the presence of râles disseminated throughout the entire extent of the lungs, and particularly this tendency to hemorrhage of which I have already spoken, and finally, when the end is nigh, all the phenomena which characterize pernicious jaundice (ictère grave).

Hypertrophic cirrhosis is always a very serious malady. Ordinarily its debut is insidious and obscure; it commences as a gastro-enteritis; the

liver becomes enlarged, jaundice supervenes, and the disease is in the way of progress.

When the malady is simple and without complication, it may have a very long duration, it may be prolonged two, four, six, ten years, even, presenting alternatives of exacerbation and remission. Then a moment arrives when the patients succumb.

In effect, no well authenticated case of recovery from hypertrophic cirrhosis has ever been reported. It is true that at the present moment we have in our service a patient who at the time he entered the service, was very weak and had become very thin; at present he is very much better and seems to be fast regaining strength and health. But is this cure? We have, unhappily, many reasons to doubt it, for, as I have just said, this amelioration is often but momentary; for a few weeks, and sometimes even for several months, the patient seems to enjoy good health, then the disease pursues its course with even greater intensity than before.

The termination of this form of cirrhosis is, then, death, at a more or less advanced period. It supervenes in different ways; sometimes it is brought about by some intercurrent malady, entirely independent of the principal disease; again, it may be brought about by some lesion due to the condition of the liver, such as peritonitis, or as we observed in our patient of last year, by pleuritis, through propagation of the inflammation from that part of the peritoneum covering the diaphragm. But this mode of termination is rare, and most frequently the patients succumb through the effects of a partial peritonitis, causing numerous adhesions between the peritoneum and the intestines.

Patients again often succumb through the jaundice. After a certain time, in many patients, all the phenomena of pernicious jaundice supervene; there is abundant hemorrhage; they fall into a comatose condition; the pulse, although frequent, becomes excessively feeble, and the patients succumb. It has been said that this is the most frequent termination of the malady. It is an error; all that can be said is, that this is one of the modes of termination of hypertrophic cirrhosis.

The prognosis, then, is very grave. But it must be remembered that although no cases of complete recovery are known, still the malady is often of a very long duration; sometimes the patient lives five, eight, or ten years.

But if such be the case for simple uncomplicated hypertrophic cirrhosis, a distinction must be established, as regards duration, for those cases where the atrophic form exists conjointly with it. In these mixed cases, in effect, the prognosis is of much greater gravity and death supervenes much more rapidly.

I will not need to linger long over the consideration of the diagnosis of this disease. I have shown you how it was to be distinguished from the atrophic form of cirrhosis; and how, when the symptoms proper to both were found co-existent in the same individual, it might be affirmed that such a case constituted one of those mixed forms of which I have spoken.

I will add, that you will be able to establish the differential diagnosis between cirrhosis with hypertrophy and cancer of the liver, by the rapid course of this last disease and by the presence on the surface of the organ of inequalities and nodosities, which are absolutely wanting in cirrhosis, and finally, by the very grave phenomena accompanying cancer. You will be able, also, to distinguish the malady from hydatid cysts of the liver. In both cases, it is true, there is enlargement of the organ; but when this hypertrophy is due to the presence of a cyst, it is not extended to all the liver, but is confined to that part of the organ in which the tumor is situated.

Again, in hypertrophic cirrhosis, independently of the enlargement of the liver, there is enlargement, often enormous, of the spleen.

Finally, there is rarely jaundice when hydatid cysts are present, and certain special signs, such as fluctuation and hydatic vibration or thrill, when present, aid in forming a diagnosis.

As regards the etiology of hypertrophic cirrhosis, it is, in great part, yet to be determined. Concerning the various influences under which this malady may be developed, we have but presumptions. Among the best known causes, the abuse of alcoholic stimulants, which holds the first rank for the atrophic form of cirrhosis, has an especial influence in the production of those mixed forms of which I have spoken.

The calculous diathesis has been considered as one of the frequent causes of this disease, and the pathological anatomy demonstrates in what way. Let us suppose, in effect, that there exists an obstacle to the free passage of the bile, either in the hepatic canal, in the ductus choledochus, or at any other point; there will ensue a dilatation of all the passages behind the obstacle, even to the smallest ramifications of the biliary ducts. Then supervene all the consequences which result from this arrest of bile, and which may be induced artificially by ligature of the ductus choledochus in animals. As the bile cannot be poured

into the intestine, the radicles of the hepatic ducts become dilated and the liver enlarged.

In some cases, as with one of our patients, atrophic cirrhosis supervenes after an obstruction of the ductus choledochus, and M. Hanot cites several such cases in his thesis.

Another cause which has been invoked is malarial poisoning. In effect, in persons who have long lived in malarial districts and have suffered from the fevers there generated, there exists an enlargement of the liver and spleen, whence may result serious compression on the organs which serve in transporting bile. This condition of the liver and spleen has an incontestable influence in certain cases, and we have had an example in one of the patients in our service.

As regards the treatment of this affection, there is, unfortunately, little to be said, for it is ordinarily without success. Nevertheless, in certain cases, an amelioration in the state of the patient has been brought about by the iodide of potassium, particularly when, at the same time, revulsive applications are made to the hepatic region.

M. Bucquoy cites a case of well marked cirrhosis, where complete cure was obtained by these means. But in the great proportion of cases the amelioration is but temporary, and the malady soon reappears.

Tonics should be administered, to sustain the patient's strength; the bitter preparations, to stimulate the functions of the stomach; and, finally, alkaline mixtures, to facilitate digestion.

Purgatives should be avoided; these patients are liable to become subject to incoercible diarrhœa, and sometimes a purgative suffices primarily to provoke it.

In this malady, also, calomel, so much lauded in England in the treatment of diseases of the liver, does not appear to be of any utility.

Finally, when the liver is considerably hypertrophied, good results may sometimes be obtained from certain alkaline mineral waters, which have considerable action in enlargement of various organs. I would specially indicate at this point of view the waters of Vals, of Vichy, of Carlsbad, which are indicated when there exists enlargement of the liver or spleen; when, in a word, there is any obstruction in the intestines. In these cases, the waters of which I have spoken have sometimes marvelous effects. I have known individuals returning from India with the spleen enormously enlarged, in the last stage of cachexia, present, after a season at one of these stations, considerable amelioration, and even arrive at complete cure after three or four seasons. Therefore, I do not hesitate to declare that if I had a patient with hypertrophic cirrhosis, whose means permitted him to make a sojourn at Vals or Carlsbad, or at Vichy, I would surely advise him to essay this medication.

It is hardly necessary to say that in such cases diet should receive careful attention, and abundance of nourishing food be given, to oppose as much as possible the incessant progress of the cachexia which continually menaces the lives of patients in hypertrophic cirrhosis.

COMMUNICATIONS.

CLINICAL STUDIES OF INEBRIETY.

BY T. D. CROTHERS, M.D.,
Of Hartford Conn., Superintendent of Walnut Lodge.

Relations of Inebriety to Life Insurance.

(*Continued from page* 342).

A leading officer in an eastern company said that inebriety was the Waterloo upon which we are all wrecking. Every year the death rates from inebriety are increasing beyond all proportion to the vigilance and specific instructions of both officers and agents. The data from which the longevity tables are calculated are unreliable, because they do not represent the natural life of those who have died. The principles deduced from these are equally false, because the company are not insuring healthy lives, and the reported causes of deaths are untrue. The rates based on these false figures are also unjust to both the company and the insured; and there is not a company in the country who is not carrying a large proportion of inebriates among its policy holders. For this the companies are in some measure responsible, and for which they pay dearly, in the increased losses, year after year. Life insurance does not insure, when one-third of its policy-holders are inebriates and its officers are drinking, horse-racing men. Life insurance cannot literally insure, when they admit inebriates of all grades, under the name of moderate and occasional drinkers. As at present managed this condition is inevitable, and every company is insuring inebriates, no matter what their restrictions may be. In proof of this, one company made an examination of ten policies taken in one year, for ten thousand each. The reports of the local examiner showed that the risks were good, but a private history showed that two of these cases were periodic inebriates and three were moderate or occasional drinkers. The agents and local examiners were conscientious, and did the best they could, but had been deceived. This was the condition in one of the

best companies, where total abstainers only were insured. A universal sense of insecurity and alarm pervades the mind of careful companies, and the inquiry, What can we do? comes up from all sides. The answer may be summed up in the following propositions:—

1st. The only remedy is in a study and recognition of inebriety as a disease, governed by certain fixed laws, starting from definite causes that are more or less apparent, and passing, from stage to stage, into full development and decline. 2d. Such study will indicate the conditions which encourage or retard the growth of inebriety, and all the circumstances which favor its development, with the influences of heredity, and other facts governing the longevity and risk of life in the patient. 3d. When the local examiners are competent to make such a study of the case, and will realize that every evidence of moderate drinking is a symptom of a grave disease, that may go on to maturity, or in some instances remain stationary a lifetime, but at all times threatens a fatal outbreak; then the companies may be able to fairly insure in justice to all. 4th. Until such a study is made, every company is doing a perilous business, whose success depends more on coincidence than on skill and management. This question is not only a pecuniary one for the company, but one of social science, involving vast interests in both the individual and community.

When inebriety is recognized as a disease, and treated accordingly, many of the evils which follow from it will be lessened and prevented. The too frequent incident of men of property and culture occupying responsible positions in life, going down rapidly as inebriates, not only destroying themselves and family, but leaving an entailment of misery behind them, without a practical effort to save them, other than appeals to their diseased will to recover, is a disgrace to the intelligence of the age. The business ignorance of life insurance companies that will insure moderate drinkers, and the stupidity that will depend on the opinions of non-experts on questions requiring the best trained talent, deserves to fail, for they are inviting the very conditions which make failure certain. In support of these facts I am able to present the histories of some cases which have come under my observation and that of the officers of some of the companies.

Inebriety from Inheritance; Concealed for Years. Heavily Insured. Death, etc.

Case 1.—B. was a business man, whose father was a moderate drinker and mother died of consumption soon after his birth. He was a free liver up to thirty, when he began to have paroxysms of drinking: they began after some business failures, and recurred every four or five months, with distinct free intervals. These increased until they came on every three or four weeks. He was insured at this time for fifty thousand dollars, in three different companies; he claimed in his policies to be only a moderate drinker. When the paroxysm came on he would go away to the country, and remain in some quiet place for a week, intoxicated nearly all the time, then recover and come home, and remain perfectly sober for a long time.

The most unusual symptom of his case was his intense desire to conceal his real condition, even from his family, which he succeeded in doing for a long time. He seemed to have no idea of deceiving the insurance company, but like all others of this class, was full of delusions that he could stop himself, and had no disease of any kind. The agent was an intimate friend, and did not suspect his condition until death, which followed a protracted paroxysm of drink. The local examiner was a moderate drinker, and laughed at the idea of disease. The companies paid the amount.

Inebriety from Exhaustion; Concealed; Insured; Death.

Case 2.—C. was a speculator and politician, who had been sun-struck at twenty-five, and used spirits from this time more or less, to intoxication. He was an irregular drinker; sometimes he would be sober for months, then he would go away to some distant city, and drink hard at night, for many days. He was prominent in all efforts to help on the temperance cause, and claimed to be suffering from overwork. In this condition he secured an insurance of eighty thousand dollars on his life, without any hesitation by either agent or examiner. He claimed to use spirits at times, but only occasionally. He made no effort to conceal his condition, only it was noticed that he went to more distant cities when drinking. Two years after he died, and the certificate was signed as death from pneumonia. He had returned from one of his severe paroxysms, worn out, and died of general exhaustion. The agent and physician were both deceived, and never suspected excess in drinking. The insurance was paid, and two years later, when his property came up for settlement, these facts appeared.

Inebriety, Periodical; Concealed; Insured; Death; Contest; Defeat.

Case 3.—D. was a clergyman who inherited a nervous diathesis, and began to drink in college,

from some obscure cause, and later, when he became a periodic inebriate, retired from active service, and drank only at night, in his room. He would not meet any one while in this condition, and claimed that he was sick, and used spirits to relieve pain. He was insured for thirty thousand dollars, in the best companies, and the risk was thought to be a good one. No one supposed that he was an inebriate; finally he was found dead, from what the physicians called apoplexy. One of the companies refused to pay, and set up the defence of inebriety, which they failed to prove, because the local physicians doubted if he could drink in secret for years, without making a public display of it. They also considered it impossible for any one to drink to excess, so as to injure his health, without a combination of symptoms which would have been apparent to all. The company was obliged to pay at last, and the agent and examiner were convinced that he did not have inebreity.

Inebriety from Shock; Insured; Not Considered Dangerous by Examiners.

Case 4.—E., a country merchant, who was severely injured by a fall, was profoundly agitated at the prospect of death, and began to drink alcohol to excess. From this time he used whisky on all occasions when he felt exhausted, being intoxicated once or twice a week, at home. He applied for insurance and was accepted as a moderate drinker. An officer of one of the companies, staying all night at the hotel, found him much intoxicated, and went to the agent, who said he was not an inebriate, having been so for many years. The local examiner was of the same opinion, and asserted that this was not in any way uncommon; that he had seen many persons drinking for years, who were not, in his opinion, injured by it. The policy was canceled and the officer found, in this State, over two hundred thousand dollars of insurance on inebriates in like condition.

Case 5 was a periodical inebriate, with sixty thousand dollars insured on his life, who had two distinct attacks of delirium tremens. The agent and local examiner both regarded this case as of no particular danger, based on the statements of the patient that he could and would stop at any time. They acknowledged that the delirium tremens was possibly dangerous, but short of this nothing was alarming, and the chance of a long life quite good. The physician wrote me that he doubted the injurious effects of alcohol where the article was good, and it was taken after eating. He also believed that the use of alcohol in the parent made it possible for the son to drink with greater safety.

Case 6.—An inebriate with a marked history of insanity was heavily insured in a New York company. The medical examiner and president of the company differed as to the danger of the risk, and referred the case to me. The man was a constant inebriate, who never seemed intoxicated, but was constantly under the influence of spirits; he seemed capable of transacting business and talked sensibly. The medical examiner called this an average case of vice or habit, in which the person was not generally the worse for the excess, and that as long as he remained in his present condition the risk to the company was no greater than in any other case of over work or over eating. The president insisted that the case was dangerous, and that the natural period of life was constantly lessened by this excess, and that the company should not insure such a life. The policy was canceled, and patient died in an insane asylum within a few months.

Case 7.—A man heavily insured was taken violently insane and died of some obscure brain trouble. The company found that he had been an impulsive inebriate for years before he was insured, and that the local examiner considered him a mere pleasure seeking man, with the habit of drink; not diseased, but simply giving way to his passions from time to time.

Case 8.—A broken-down lawyer, became heavily insured and died soon after. The facts were as follows: He was an inebriate from inheritance, but drank away from home and concealed his real condition from his friends. The local examiner was fully aware of his excesses, but as long as he returned in apparent health did not consider it of any moment. He evidently realized that he could not live long, and took this means of securing a competency for his family. The company contested the case on this ground, but was defeated.

Case 9.—A man with fifty thousand insurance on his life broke his leg and died of gangrene a week later. It came out on the examination that he had been an inebriate for years, and both the agent and local examiner had known of this fact, but he was down on the policy as a moderate drinker, had been accepted by the company, and examined for an additional insurance. The local examiner gave the same reason of vice, and doubt as to the bad effects of spirits if taken as they should be, as given by other instances.

Case 10.—Was the son of a very rich man, who had been for years a chronic inebriate. He came under my care, and soon after an agent of a life insurance company wished me to give a statement of the case, with a general prognosis.

This I did, stating the facts which were apparent to the most general observation. Six weeks later the agent and a local examiner passed him for a ten thousand dollar policy. One month later twenty thousand more was put on his life. The local examiner remarked, in answer to my surprise that any company would take such a risk, that his father could pay the premium, and that all such cases were no greater risk than others, particularly when they were certain of the premium. It subsequently appeared that the father was anxious to get back some of the money he was expending on him; knowing that he could not be helped permanently, or would not live long, he sought this means to make his death profitable. He was very retired for two years, until death, and the company paid the insurance.

Case 11.—Was a similar chronic one, in which the father-in-law procured a heavy insurance, and kept it up for years, on the patient. He was a few weeks under my care, and then taken to the country, his friends manifesting great care to keep him from public notice.

Case 12.—An officer of a reputable company, who was insured for a large amount of money, used alcohol to excess every week. The rules of the company forbid any insurance of moderate drinkers, and yet this officer claimed that he merely used it for medicine. This case came under my care for advice. I gave a decided opinion, which was put away as ultra and fanatical. The officer resigned and died soon after; his insurance was paid, but another officer of the company said his example and diseased opinions cost the company over three hundred thousand dollars.

Case 13.—Was an inebriate physician, who for many years was a local examiner for two companies, who only insured abstainers. In twenty-one cases passed by him, nine were inebriates, and six of these nine died within two years and the company paid the policies. He died at last, with forty thousand insurance, and the company settled. He was an honest, conscientious man, who believed that all these cases were fair risks for the company.

Case 14.—A noted statesman, who was a periodic inebriate, was insured in different companies for eighty thousand dollars. Every local examiner accepted his statement that he could stop any time, and only drank when suffering from malaria, and for five years, until death, his premiums were accepted.

Case 15.—Was alternately insane, and an inebriate, who was insured by his friends at the company's office, and on the statements of friends who were thought to be reputable; no inquiry was made into his past history, from outside parties. His son, an inebriate under my care, was also insured; both died, and the company paid the policies.

Case 17.—Is now insured for a large sum, and is using alcohol constantly, to intoxication. The company's agent called and advised him to stop the use of alcohol, and that is all that has been done. As long as he pays the premiums promptly no questions are asked, but when he fails to do this, they will probably discover that he is an inebriate, and cancel his policy.

Case 18.—Is a chronic repeater, who goes from one asylum to another, and drinks in the intervals. The officers of all the companies know of this state, but as long as he is prompt in his payments they do not discover his condition. He was insured in this condition at the home office, and urged to give up the use of alcohol. This he faithfully promised, but goes on from bad to worse, in the full conviction that at death his family will get forty thousand dollars.

These and other cases which might be cited point conclusively to the utter fallacy of forming any conclusions from the vital statistics of life insurance companies as at present managed. No rigid instructions to agents can avail when these men are incompetent to make the most general examination. Local examiners engaged in general practice cannot, for the mere pittance they receive, prepare themselves and make the necessary careful study of the case. The company cannot expect any better state of things as long as they trust to incompetent agents questions which only skilled men can determine. Every local examiner and agent is called to determine conditions and probabilities that are more vital and important than questions of insanity. No answers to a stated class of questions can apply, or bring out the facts most essential in a large majority of cases. The presence of inebriety is often a most difficult question to determine, but when present its influence on longevity cannot be mistaken, and its fatality exceeds that of all other diseases. Owing to the confusion of opinion, the early stages are overlooked, and it is only recognized when chronic stages come on, and even then a belief prevails that the victim is suffering from a voluntary disorder more or less under his control. Life insurance companies should take up this study as a measure of self protection, if for nothing else.

—The Atlanta *Medical and Surgical Journal* has become the Atlanta *Medical Register.*

A SUGGESTION IN THE MECHANICAL TREATMENT OF ACUTE INFLAMMATORY CONDITIONS OF THE ANKLE JOINT.

BY CHARLES F. STILLMAN, M.D.,

Of New York,

Delegate from American Medical Association to Foreign Societies, for 1881-82.

In the treatment of sprains and other injuries about the ankle joint, it has long been a desideratum to possess a splint which would allow a local extension of the part, and also motion when required; as the prolonged continuance of the foot in one position is apt to produce adhesions between the tendons and their sheaths, and often graver disorders, and thus prolong treatment.

The splint figured in engraving No. 1, devised by me for this purpose, is so constructed as to admit a local extension, and also motion. It also allows fixation of the joint at any angle, with or without extension, and permits exposure of the surface about the joint for inspection and applications. It is made of steel, and fastened to a leather or felt sole below, and two zinc or copper plates above, as in Fig. 1, or to a low laced shoe below and padded girth above, according to the acuteness of the symptoms.

FIG. 1.

FIG. 2.

If the former be used, it is fastened firmly to the foot and leg by starch bandage, or plaster-of-Paris, as in Fig. 2. The local extension is produced by separating the attachments, as far as practicable or necessary to relieve pain, then clamping the uppermost clamp on the upper strip (which is the extension strip). This distance between the attachments is then retained at all angles the foot assumes with the leg, as in Fig. 3, and the weight of the body and the pressure from the constant muscular contraction are both removed from the joint and its neighborhood, and transferred to the splint, which acts as a false joint, to do the work of the true one while it is laid up for repairs.

FIG. 3.

Fixation is produced at any angle by simply clamping the three clamps.

In a case of sprain or any injury in or about the ankle joint, the surgeon, by the use of this splint, can remove all weight of the body from the joint, and yet have it completely under his control, producing either fixation or motion, as he may wish, and still leave the joint exposed for elastic compression and applications.

This brace, in its modified form, is also of the greatest use to patients who are recovering the use of the foot after treatment of an acute sprain or other injury, as it assists the ankle by transferring the weight of the body from the ankle joint to the splint, and prevents it from turning under.

104 *West 34th St., N. Y.*

HOSPITAL REPORTS.

UNIVERSITY OF PENNSYLVANIA.

SERVICE OF JOHN ASHHURST, JR., M.D.,
Professor of Clinical Surgery.

Reported by GUY HINSDALE, M.D.

Railroad Injury.

CASE 1.—This patient was admitted the night before last. While riding on the platform of a freight car, his feet being braced against another car behind, the train suddenly came to a standstill, and as the cars jolted together, he received his injury. After an accident of this kind we often find a fracture of the femur; the bone is apt to give way at about its middle. The force in this case having been equally applied to both feet, the injury was less severe than might have happened under other circumstances. We may thus have from the same blow very different results, varying according to the position of the subject at the time of the accident. There is possibly a fracture of the fibula on the right side; there is a great deal of localized tenderness at the upper fifth of the bone, and there is great swelling and tenderness of the muscles. You observe also the swelling of the knee joint. The way in which we decide whether there is effusion in the knee joint is by tapping the patella; if there is effusion into the joint the bone can be pushed down and will rebound, it will float, as it were. But here it does not float, and the effusion is probably in the bursa, outside of the joint. In the treatment of a case of this kind we should simply make a double inclined plane by placing a pillow under the knee. The patient is to be kept at perfect rest and applications of lead water and laudanum made to the joint. By passing a bandage under the pillow and tying it up on either side we make a sort of splint, and give the proper support. One of the most interesting features of the case is the illustration of the different effects produced by a diffused force and by a concentrated blow.

Warty Ulcer.

CASE 2.—This patient declines treatment. He presents a rare form of disease, and I bring him before you in order that you may be familiar with it. He has a history of an injury received from a cart-wheel a good many years ago. The wound did not heal soundly, but underwent a process of ulceration

and re-ulceration, and during the last few months has extended deeply into the tissues of the heel. It has now the characteristic appearance of the so-called "warty ulcer," and involves the bone. This is an illustration of the change from a simple inflammatory condition to disease of a malignant type. The epithelial formation, instead of being limited to the surface, proceeds inward. We see a similar change in epithelioma of the lip, beginning usually as an indurated fissure, and caused by some local irritation, in many instances, apparently, by the use of a short pipe.

We are, therefore, dealing with what is called the "warty ulcer of Marjolin." The late Mr. Collis, of Dublin, reported some cases of this affection benefited, if not cured, in their early stages, by the application of bismuth or of ice. But where the disease is complicated by a carious condition of the bone, reaching such an advanced stage as in the present instance, such applications are futile. The disease, however, continues, for a long time at least, to be a local affection, and the general health may remain unimpaired for many years.

The course which I recommend to this man is amputation of the foot. The sore may partially heal again, as it has on previous occasions; but he will never have a useful limb. As he turns the foot toward you, notice the great depth of the ulceration, and also the peculiar offensiveness of the discharge. Along the margin of the sore there are large, warty granulations, of the size of a Lima bean. These are characteristic; you can distinguish them from ordinary granulations by their large, warty appearance.

Caries of the Calcaneum.

Case 3.—This little fellow has also disease of the heel; there is caries or ulceration of the bone, and it requires an operation, but not amputation, as I advised in the last case. We will remove merely the diseased parts. There are two sinuses, one on either side of the tendo-achillis, and the bone is extensively involved. I shall do here an operation which Sédillot, the eminent surgeon of Strasbourg, has described under the name of *évidement*, and which consists in very free gouging, leaving, however, a shell of bone next to the periosteum. Prof. Ollier, of Lyons, removes the whole bone in cases of this nature, by the operation of *sub-periosteal excision*, the periosteum being carefully preserved, in order that, by its osteo-genetic power, the excised portion may be reproduced. Another advantage of sub-periosteal over simple excision is that by preserving the membrane in question the attachments of the various muscles are not disturbed. Even when there is no reproduction, however, the result in cases of this kind is often very satisfactory, the wound filling with granulations, which are subsequently transformed into a dense, fibrous, cicatricial mass.

Both Sédillot's and Ollier's methods are of value in suitable cases, and either is preferable to amputation.

Note.—The limb having been rendered bloodless by the use of Esmarch's apparatus, a curved incision, with its convexity downward, was then made upon the side of the os calcis; the dead bone was removed by the gouge and other instruments, and a deep cavity in the bone was left. This cavity was stuffed with oiled lint before removing the Esmarch's tube, and there was very little oozing of blood. A roller bandage was then applied, to support the wound.

Syphilis.

Case 4.—This patient is affected with a venereal disease, with somewhat equivocal symptoms. He has a sore on the penis, which commenced three months ago; there is now a certain amount of induration about it, but it is not characteristic, and might be the result of cauterization. Some of the glands in the groin have suppurated, which is not a common occurrence in the syphilitic bubo. There is, however, present, as you observe, a well-marked secondary syphilitic eruption. It is in its early stage, and is papular. The primary sore showed itself three months ago, and the ulceration of the groin four weeks ago. The chancroidal bubo is usually found on one side only, and commonly on that of the sore from which it arises, though it is occasionally found on the opposite side, as the result of the crossing of the lymphatics on the upper surface of the penis. The chancroidal bubo, too, affects only superficial glands, and but one at a time; hence it is not only *monolateral*, but also is *monoganglionic*. A simple sympathetic bubo may accompany chancroid, and be cured by counter-irritation and other local measures, but the true chancroidal bubo invariably tends to suppuration, and the resulting ulcer is precisely similar in character to the original chancroid, and furnishes a contagious and auto-inoculable pus. The bubo of syphilis, on the other hand, involves a number of glands at once, and usually those of both groins; it is, therefore, *bilateral* and *poly-ganglionic*. The glands are indurated and distinct, not matted together by inflammation, and are seldom painful. Sometimes the central gland of the group is larger than those around it, forming what certain French writers have humorously called the "pleiade ganglionaire." The syphilitic bubo has in itself little or no tendency to suppurate and, when suppuration occurs, as it has in the case before us, this is due either to the influence of some external source of irritation, to the patient's possessing a scrofulous diathesis, or, perhaps, to the coexistence of a chancroid.

In the treatment of syphilis, mercury and the iodide of potassium are unquestionably the most valuable remedies. Most authorities teach that the chancre heals more quickly when mercury is given than when it is withheld, during the primary stage, and that the development of secondary lesions is, if not entirely prevented by the use of this drug, at least delayed, while the symptoms themselves are rendered milder.

Others, however, maintain that no mercury should be given until the beginning of the secondary stage. My own practice is to give mercury as soon as the diagnosis of syphilis is certain, being careful, of course, to avoid salivation, and stopping its administration if it seems to irritate the patient's system. If, however, there is any doubt as to the nature of the disease, or if mercury is for any reason contra-indicated, it is much better to be satisfied with local treatment, and the use of tonics if they should be required.

In the secondary stage of syphilis I prefer mercurial inunction to the internal use of the drug; half a drachm of the simple mercurial ointment may be well rubbed into the inside of the thighs, night and morning, or into the soles of the feet. The only objection to the treatment by inunction is that, if the patient's skin be very irritable, mercurial eczema may be developed. This, however, can usually be avoided by taking care always to thoroughly wash off the old ointment before making a new application. In children a few grains of the ointment may be smeared upon the belly-band.

In the first stage of syphilis, I would advise the use of the green iodide of mercury, which may be given in pill in combination with opium, to prevent its irritating the bowels. In the tertiary stage, if mercury is needed, the bichloride may be employed, combined with the iodide of potassium, and in connection with tonics, iron and cod-liver oil. No local treatment is required for the early cutaneous manifestions of syphilis, but in the later, ulcerative forms, an ointment of iodoform containing gr. xv to ℥j may sometimes be employed with advantage.

Medical Societies.

INTERNATIONAL MEDICAL CONGRESS.

Abstracts of Papers.

While it will not be possible for us to give epitomes of all the numerous papers read before the International Congress, we select abstracts of such as seem the most important and generally interesting, quoting them from the London medical weeklies.

ON THE RÔLE OF SYPHILIS AS A CAUSE OF LOCOMOTOR ATAXY.

By W. Erb, M.D. (Leipzig). Professor Erb said that his recently published statistics on one hundred new cases of typical tabes in male adults (*Medicinische Centralblatt*, 1881, Nos. 11 and 12), showed: Cases without previous infection, twelve per cent.; with previous infection, eighty-eight per cent.; among them, with secondary syphilis, fifty-nine per cent; and with chancre, without secondary syphilis, twenty-nine per cent. Up to June 1st he had observed thirteen other cases. Among them there was but one without previous infection; of the remaining twelve, eight had had secondary syphilis, four only a chancre. In most cases the first symptoms of tabes occurred from the fifth to the fifteenth year after infection; a considerable fraction, however, occurred from three to five years after infection. On examining all male adults over twenty-five years old, of his *clientèle*, who did not suffer from tabes, and not directly from syphilis, he found seventy-seven per cent. who were never infected; twelve per cent. who had formerly secondary syphilis; and eleven per cent. who had only a chancre. The only possible logical conclusion from these facts was, that there must be a certain etiological connection between syphilis and tabes.

LOCALIZATION OF DISEASE IN THE BRAIN AND SPINAL CORD.

A discussion on this subject was opened by Dr. Brown-Séquard (Paris), who read a paper in which the following questions were proposed for consideration: 1. Are there parts of the brain and spinal cord which, being diseased, give rise to symptoms which no other parts can produce? 2. What is the diagnostic value of certain symptoms to show the seat of disease in the brain or in the spinal cord? 3. What gains have we made in diagnosis by the recent researches on localization of disease in the cerebro-spinal centres? As regards the first of these questions, he tried to show that, although there is no symptom which alone possesses an absolute pathognomonic value concerning the seat of the disease, there are, however, morbid manifestations, the coexistence of which establishes almost certainly, and sometimes quite certainly, that special parts are diseased. As regards the second question, he spoke of the connection: 1st, of aphasia with disease of the third frontal convolution, the island of Reil, and the occipital lobe on the left or on the right side; 2d, of the Jacksonian convulsions with some cerebral convolutions; 3d, of brachial, crural, facial paralysis, and of other kinds of monoplegia, with lesions of certain convolutions; 4th, of cerebral hemianæsthesia with disease of the optic thalamus or of the posterior part of the internal capsule; 5th, of hemichorea with disease of the corpus striatum or of the anterior part of the internal capsule; 6th, of titubation with disease of the cerebellum, and of some parts of the base of the brain; 7th, of diabetes with disease of the floor of the fourth ventricle; 8th, of labio-glosso-laryngeal paralysis with disease of certain groups of nerve-cells of the medulla oblongata; 9th, of some symptoms of labio-locomotor ataxy with disease of certain parts, and of other of the symptoms of that affection with disease of other parts of the posterior columns of the spinal cord; 10th, of paranæsthesia with disease of the central parts of the lumbo-dorsal enlargement of the spinal cord; 11th, of progressive muscular atrophy with atrophy of the nerve-cells of the anterior gray cornua of the spinal cord; 12th, of the essential infantile paralysis with small foci of inflammation of the part of the gray matter just named; 13th, of intermittent paraplegia with ischæmia of the dorso-lumbar enlargement of the spinal cord. As regards the third question, he showed that considerable advances had recently been made, although much less than was generally believed.

CONTRIBUTIONS TOWARD JACKSON'S EPILEPSY AND LOCALIZATION OF THE ARM CENTRE.

By F. Müller, M.D. (Graz). The following were the author's conclusions: 1st. Jackson's epilepsy is essentially different in clinical respects from genuine epilepsy. (*a*) The attack consists, as a rule, only of clonic convulsions; the ranges being generally very much developed, and beginning always in the same muscle or group of muscles, it remains either localized altogether, or extends only slowly. (*b*) Consciousness remains intact during the whole, or at any rate the greater part, of the attack, the patient being, in fact, the observer of his own attack. 2d. Jackson's epilepsy points, in its

well-developed forms, with certainty, to a cortical lesion, and allows, with the aid of the paralytic symptoms (different forms of monoplegia), which are either simultaneously present or follow the attack, the formation of a diagnosis not only of localization, but often also of the nature of the lesion. 3d. Oculo-pupillary and paralytic symptoms, *e.g.*, ptosis, narrowing of the pupil without refractory rigidity, etc., seem to form a frequent and very remarkable feature in the clinical picture. 4th. The arm-centre is situated in the middle third of the anterior and posterior central convolution, and in the adjoining part of the fissure of Rolando. 5th. Gradual destruction of this region by the formation of a tumor produces Jackson's epilepsy (which always begins in the arm), and in the further progress, paralysis of the entire upper extremity; while the muscles of the face, trunk, and the lower extremities remain completely intact from paralysis.

ON ADDISON'S DISEASE.

By E. Headlam Greenhow, M.D., F.R.S. (London). Dr. Greenhow referred to cases of disease of the suprarenal capsules published previously to Addison's discovery, and described a typical case hitherto unpublished. He also gave an account of the constitutional symptoms, the bronzing of the skin, the pathological appearances, the diagnosis, the causes of the disease, and its pathology. He said that the symptoms of Addison's disease were not due to the destruction of the suprarenal capsules and abrogation of their proper function; for, in some recorded instances, their normal structure must have been destroyed by the pathological process of the disease itself, previously to the development of the symptoms; and it had often been entirely supplanted by cancerous deposit without the occurrence of these symptoms. On the contrary, it seemed almost certain that the symptoms were to be attributed to the damage done by the pathological process to the nerves passing into the capsules, especially the branches of the pneumogastric nerve, and to the neighboring nerve-plexuses and ganglia, which were compressed by the contracting adventitious tissue in which they were embedded. The discoloration of the skin was probably due to the injurious effects of similar pressure upon the nerves of the sympathetic system, and, as shown by Dr. Paget's cases, might exist where the suprarenal capsules were healthy; but these nerves were embedded in and compressed by adventitious growth. This fact suggested a careful study of cases of pigmentation of skin unaccompanied by Addison's disease, in reference to the condition of the nerves, ganglia, and plexuses of the sympathetic system.

ON THE ORIGIN AND CURE OF SCROFULOUS NECK.

By T. Clifford Allbutt, M.A., M.D., F.R.S., (Leeds). The purpose of the paper was to insist on the local causation and the local development of many cases of scrofulous neck. While giving due weight to the undoubted influence of heredity in favoring this malady, yet that such states might be, and often were, set up in young persons by local causes alone was equally indubitable. Moreover, local causes played a large, perhaps, the chief part, in producing the malady in those originally strumous. Artificial scrofula was at least as common as the natural. Of local causes, irritation of neighboring mucous membranes was the most common; pharyngeal and aural-pharyngeal irritations being far the commonest antecedents, and the septic kind of these the most effective. The glandular enlargements were thus bubonic, and by caseous degeneration became themselves the foci of further like mischief. After minute inquiry into possible morbid influences acting through the mucous membranes, a rapid and complete cure without disfigurement must generally be sought by surgical means. Free incision and enucleation of caseous deposits were essential. The softening mass under the jaw was usually a subcutaneous abscess with more or less thickened walls, which depended upon infection from the deeper lying caseous glands. With these it communicated by sinuous channels, often very obscure. Upon the laying open of these, and the clearing out of the inner foci, care and future safety depended. Many cases were given in which Mr. Teale had coöperated with the author in carrying out these principles. Mr. F. Treves (London) agreed with Dr. Allbutt.

ON DIFFERENT FORMS OF BRIGHT'S DISEASE.

By Dr. S. Rosenstein (Leyden). The following is a summary of the paper: 1st. The anatomical basis of the disease described by Bright is the diffuse inflammation of the kidneys. 2d. Consequently those demonstrable renal changes, which are not of an inflammatory character—*e.g.*, "the kidney of pregnancy," the "cyanotic induration" observed in conditions of venous obstruction of the system, and the "pure amyloid degeneration," do not represent, though associated with anasarca and albuminuria, forms of Bright's disease, but are independent affections, strictly to be differentiated from this disease. 3d. Different forms of Bright's disease are to be distinguished anatomically as well as clinically, according to the "acute" or "chronic" course of the inflammatory process. 4th. The acute form is characterized by the emigration of colorless blood-corpuscles (as in inflammations of other organs), and by changes of the epithelial structures, to which, after a short duration, proliferation of the nuclei of the interstitial tissue is added. This form ends most frequently in recovery, and passes but extremely rarely into the chronic form. 5th. The chronic form shows anatomical changes in all the tissue elements of the kidneys. According to the preponderance of alterations in one or other of these elements, the product appears in the different conditions of the "large white," or the "variegated, smooth, contracted kidneys," or the "granular white kidney." 6th. The clinical observation of some exceptionally suitable cases renders it highly probable that the "white granular kidney" is developed from the "large white kidney," and is consequently to be looked upon as a further stage of the same process. 7th. A particular form of "granular kidney" is represented by the "red granular kidney," in so far as this form does not start from a diffuse inflammation, but from "endarteric changes" of the renal vessels, with shrinking of the glomeruli. Closely related to this form in its genesis is the

"senile contracted kidney," which is therefore to be associated with it. 8th. As to the starting point of the anatomical changes, no evidence is offered by clinical observation. The latter should, therefore, be limited to the recognition, in general, of the state of the diseased organ—*i.e.*, to recognize whether this is in the state of "enlargement" or of "contraction;" but it ought not to speak of "parenchymatous" or "interstitial" forms, as it does not possess any means of distinguishing between those.

ON RHEUMATISM, GOUT, AND RHEUMATIC GOUT.

By Jonathan Hutchinson, F.R.C.S. (London). The following propositions were laid down in this paper. 1. Rheumatism is, in the main, a liability to joint disease, brought about by exposure to cold and wet, through reflex nervous influences (a catarrhal arthritis). 2. Gout is, in the main, a liability to joint disease, brought about by certain articles of food, by defect of assimilation and of excretion (a humoral arthritis). 3. In each disease, although the joints suffer most prominently, they by no means suffer alone. 4. In each, by transmission through many generations, a diathesis is formed which is heritable, and which gives peculiarity to the diseases from which its subjects may suffer, and which stamps them as "gouty" or "rheumatic." 5. Gout and rheumatism are very frequently present together. Rheumatism is very often met with without gout, but gout is seldom present without rheumatism. Sometimes the two exist side by side, and attack the same patient at different times; but more frequently they become mixed, and produce a hybrid disease (rheumatic gout). In connection with hereditary descent, various maladies are to be affiliated with gout and rheumatic gout, which differ somewhat from both—certain forms of iritis; hemorrhagic retinitis; universal crippling rheumatism (chronic rheumatoid arthritis); some forms of glaucoma, lumbago, sciatica, and neuralgia; nodi digitorum, and possibly hæmophilia.

CHRONIC BRIGHT'S DISEASE WITHOUT ALBUMINURIA.

By F. A. Mahomed, M.D., (London). The main object of the paper was to prove that high arterial pressure in young and apparently healthy persons if it remains as a chronic condition, will produce the cardio-vascular changes of Bright's disease. It was held that the changes found in red granular kidneys are chiefly vascular in their nature; *i.e.*, thickened vessels, thickened Malpighian capsules, and fibro-hyaline intertubular thickenings; the yellow, or mixed granular kidneys, have, in addition to these interstitial small-celled growth and epithelial proliferation. Chronic Bright's disease was described as existing typically in three stages: 1. The functional stage, *i.e.*, high arterial pressure without organic change; 2. Chronic Bright's disease without albuminuria (or nephritis), *i.e.*, the cardio-vascular changes, usually with red granular kidney; 3. Chronic Bright's disease with albuminuria, or urine of low specific gravity, *i.e.*, the cardio-vascular changes with the mixed or yellow granular kidney. The present paper was to prove the existence of the second stage without albuminuria. It was founded upon sixty-one cases, in nearly all of which the urine was ascertained to be perfectly normal in quantity, specific gravity, and the absence of albumen, the latter being only occasionally present just before death. Nearly all these cases were diagnosed during life by hypertrophy of the heart and high arterial pressure. Of these, twenty-one cases were fatal, and an account of the *post-mortem* examination of each was given; in all the others the signs were unmistakable, there being in all displacement of the apex external to the nipple-line, and high arterial pressure; in many, evident thickening of the arteries, and other occasional signs. The cases were grouped as follows: cardiac failure, ten cases with eight deaths; lung failure, eleven cases, six deaths; cerebral disease, nine cases, two deaths; renal dropsy, nine cases, one death; gout, six cases; epistaxis, three cases; various medical and surgical diseases, nine cases, four deaths. There was also four cases with well-marked albuminuria, disappearing temporarily or permanently. The twenty-one fatal cases included five in which there was hypertrophy of the heart without valvular disease; in all, the vessels were thick, but there was little or no renal change.

THE ANALYTICAL STUDY OF AUSCULTATION AND PERCUSSION, WITH REFERENCE TO THE DISTINCTIVE CHARACTERS OF PULMONARY SIGNS.

By Austin Flint, M.D. (New York). The object of the paper was to indicate the pulmonary signs which are determinable by the analytical method of study, and the characters by which they may be readily distinguished. The auscultatory signs referable to respiration, the loud voice, and the whispered voice, were considered; and, afterward, the signs produced by percussion. The characters of the normal respiratory or vesicular murmur were brought into comparison with those of the sign known as the bronchial or tubular respiration. Under the head of bronchial respiration, a new term—broncho-vesicular respiration—was proposed to mark the different grades of solidification below the amount requisite for bronchial respiration. Cavernous respiration was shown to have characters clearly distinguishing it from bronchial respiration. Modifications of cavernous respiration, determinable by means of analysis and comparison, were distinguished as broncho-cavernous and vesiculo-cavernous respiration. A prolonged expiratory sound was stated, in the paper, to denote either solidification of the lung, or absence of solidification, by characters relating to pitch and quality. The existence or the absence of solidification could thus be ascertained by characters pertaining exclusively to expiration, when an inspiratory sound was wanting. The foregoing respiratory signs, referable to the loud voice, were next taken up. The distinction between simply increased vocal resonance and bronchophony was the object of analytical study. Ægophony was shown to be a modification of bronchophony, differing from the latter in an apparent distance of the resonance and an interrupted or tremulous character. Pectoriloquy, the transmission of speech or articulated words, denoted either a cavity or solidification of lung. The sounds caused by the whispered voice were considered of sufficient practical importance to form

a distinct group of physical signs. The abnormal modifications of the normal bronchial whisper were as follows: (1) increased bronchial whisper; (2) whispering bronchophony; (3) cavernous whisper; (4) whispering pectoriloquy. Whispering pectoriloquy might signify either solidification of lung or a cavity. The characters associated with the pectoriloquy enabled the auscultator to decide which one of these two anatomical conditions, in individual cases, was represented by the sign. The paper concluded with the results of the analytical study of the physical signs obtained by percussion. The number of morbid signs furnished by percussion need not exceed six, namely: (1) absence of resonance, or flatness; (2) diminished resonance, or dullness; (3) increased or vesiculo-tympanitic resonance; (4) tympanitic resonance; (5) amphoric resonance; and (6) cracked-metal resonance.

IMPROVEMENTS IN THE CONSTRUCTION AND APPLICATION OF THE FORCEPS.

By Professor Tarnier (Paris). After giving a general summary of the question, Dr. Tarnier said that two reasons had led him to give up the perineal curve of the forceps. 1. In direct applications, the forceps with the ordinary curve was easier to apply than the forceps with the perineal curve. 2. In oblique applications, the convexity resulting from the perineal curve came into contact with one of the ischio-pubic rami, and caused a deviation of the handle of the instrument, whose action then became defective. With forceps having the ordinary curve, when it was wished to impress upon the fœtal head a movement of rotation around the imaginary axis of the pelvic cavity, the handles of the instrument must describe externally an arc of a circle.

In the discussion which followed Dr. Fordyce Barker (New York) said that Tarnier's forceps was a most important step in advance. The only objection to it was the danger to the soft parts of the mother, which might be cut by it. Professor A. R. Simpson (Edinburgh) was of opinion that Tarnier's forceps was the best. It ensured traction always being made in the axis of the pelvis. The short forceps was a thing of the past. Dr. Budin (Paris) said he was a pupil of Professor Tarnier's and warmly defended his forceps, and supported it against the objections usually urged against it. Dr. Matthews Duncan (London) stated that, although Tarnier's forceps was an attempt at a scientific instrument, scientific instruments were not always necessarily the best. He thought the question could only be settled by experience. Professor Stephenson (Aberdeen) saw no improvement on the ordinary forceps in the modifications made by Dr. Tarnier. Dr. R. Barnes (London) considered Tarnier's forceps the greatest advance in scientific midwifery in late years. He, like Dr. Budin, supported it, and combated the various criticisms made by different speakers. Dr. Lombe Atthill (Dublin) had tried Tarnier's forceps, but preferred Barnes' long forceps, which he always used with success and satisfaction to himself.

BATTEY'S OPERATION.

Dr. Battey described his operation, and a discussion upon it followed. Dr. Marcy (Boston) had done two oöphorectomies *per vaginam*. Dr. Priestly (London) thanked Dr. Battey for his valuable paper. He was astonished at the revolution in abdominal surgery. Battey's operation should not be performed except as a *dernier ressort*. He had observed that the ovaries varied in size, just like the testicles. Mr. Knowsley Thornton (London) had operated five times, with success. He was disappointed at the large mortality of the operation. He had failed to cure dysmenorrhœa by it. He complained that the after history of the cases operated on had not been fully reported. Professor Martin (Berlin) had twice performed oöphorectomy. The first case was one of uterine tumor, and was successful. The second case was one of dysmenorrhœa, and the operation had not relieved the symptoms for the cure of which it had been undertaken. Dr. Heywood Smith (London) said that the presence of adhesions was a frequent source of difficulty. Mr. Lawson Tait (Birmingham) was pleased to find the operation so favorably received. He had had five deaths out of twenty-six cases, in which he had removed the ovaries on account of fibroid tumors. Dr. Bantock (London) related a case in which he had operated for the relief of menorrhagia. Dr. Goodell (New York) had not had much experience in the operation. He asked why it was so fatal. He had performed the operation by the vagina and by the abdomen. He preferred the abdominal section, and in future should operate by that direction. He was of opinion that Battey's operation should be resorted to in cases of insanity. Mr. Spencer Wells (London) had only operated once, and then with success. It was difficult to avoid wounding the intestines. He had not seen cases requiring the operation. Dr. Pallen (New York) had performed the operation several times. Dr. Matthews Duncan had sanctioned the operation in one case. The sufferings of neurotic women were exaggerated.

(*To be continued.*)

EDITORIAL DEPARTMENT.

PERISCOPE.

Eserine in Atropia Poisoning.

Although experimental research has long since proved the antagonistic effects of belladonna and calabar bean, but few cases of poisoning, where one has been used as an antidote for the other, have hitherto been published. We, therefore, copy in full, from the Louisville *Medical News*, the following report by Dr. Andrew Seargent, of a case of atropia poisoning successfully treated by eserine:—

Mr. R., aged thirty-four years, occupation

saloon keeper, on the evening of July 21, 1881, took by mistake half a grain of sulphate atropia and three-fourths of a grain sulphate of morphia immediately before eating supper, at 6.30 o'clock, P.M. Soon afterward he discovered the mistake he had made, and went to the druggist who had filled the prescription. The druggist became alarmed, and at once gave him thirty grains of pulv. ipecac and told him to consult a physician. He went to Dr. J. A. Brady, who started him with a friend to the City Hospital, with the instruction to take active exercise as long as possible. He arrived at the hospital at 8.15 P.M., unable to walk without assistance, and exhibiting all the characteristic signs of atropia poisoning. His pulse at this time was 120 and respiration 30. The emetic the druggist had administered having failed to produce emesis, I gave him thirty grains sulphate of zinc. Ten minutes later I gave him an ounce of mustard in a strong solution of common salt, followed by warm water, given freely. This soon produced free emesis, but failed to improve his condition in the least. He grew rapidly worse, and soon became comatose; pulse 136; respiration 36; the exercise had to be discontinued. I sent a messenger for some eserine, not having any at hand, but administered one grain of sulphate morphia hypodermically at 9.10 o'clock, P.M. This produced no change in his condition, and in about fifteen minutes he had a convulsion, which lasted for some time, during which there was very decided opisthotonos without any apparent rigidity of the extremities. At 9.40 o'clock, P.M., his pulse was 140, respiration 9 to the minute, and very shallow. Dr. J. A. Brady, his family physician, whom I had sent for, having arrived, we held a brief consultation and decided to stimulate respiration by means of electricity, and to draw off the urine. Electricity was continued for an hour with only a slight improvement in his respiration, and in attempting to draw off the urine we found the bladder almost empty.

At 10.45 P.M. we obtained a solution of eserine and administered one-sixteenth of a grain hypodermically. In less than ten minutes his respiration and circulation began sensibly to improve. In fifteen minutes he was able to raise himself up, and asked for a drink of water, saying that he felt as bright as a new twenty-dollar gold piece. He now vomited quite freely, and walked to the ward assigned him, with a little assistance (11.15 P.M.).

At 1.30 o'clock, A.M. I was called to see him, and found him comatose and oblivious to his surroundings. Pulse was 120, very weak, respiration 14, pupils as widely dilated as when first seen. I immediately gave him one twenty-fourth grain of eserine hypodermically. He began to improve at once, and in ten minutes was wide awake and perfectly rational. I again used the catheter, but did not find any urine, although the patient thought his bladder was full.

Visited the patient at 6 o'clock, A.M., July 22d, and found him sitting up and anxious to leave the hospital. Respiration deep and 18 to the minute; pulse regular and 96 to the minute: pupils still dilated, and mouth dry. Patient was unable to urinate.

I visited him again at 9.30 A.M. and found everything normal except pupils, which were slightly dilated. Patient had not urinated, and had no desire to do so. I then ordered an infusion of digitalis with acetate of potash, which soon produced free diuresis, and in due time the patient was discharged well.

The Treatment of Spermatorrhœa.

The Chicago *Medical Journal and Examiner* contains an excellent paper on the pathology of involuntary spermatic fluxes, which was read before the Eastern Kansas Medical Society, by Dr. Geo. H. Picard, of Topeka, Kan., who holds, with Lallemand, that spermatorrhœa is a local disease, a production of an irritation of the prostatic portion of the urethra and seminal ducts, and not a neurosis, as claimed by more recent writers. With regard to treatment, he says:—

Be certain of the diagnosis; it is a somewhat rare disorder, and all passive fluxes from the urethra should be doubtful until the microscope has told the story; treat nervous complications as intelligently as you would those arising from any other cause; and use some approved form of local treatment. I agree with Bartholow, that the *porte caustique* of Lallemand is a somewhat dangerous agent in unskilled hands, but it is very efficient in the hands of the surgeon who knows the parts and the instrument. The tanno-glycerine is about as desirable as the caustic, and has the merit of being harmless. I have injected a drachm or more of the tanno-glycerine—℥-℥—at intervals of a week or so, until a cure was effected. These injections may be made in various ways. The universal syringe can be attached by means of the screw to a silver catheter, which can be introduced into the prostatic urethra. There are hard-rubber syringes especially constructed with long, curved, bulb-tipped nozzles, which answer the purpose most admirably. Various other astringent injections are of great service, the only requisite on the part of the surgeon being ordinary skill and attention.

Conservative Surgery.

In reply to an article by Dr. J. B. Murdoch, published in the Cincinnati *Lancet and Clinic*, June 11th, 1881, in which the writer holds that it is impossible for any human limb to retain its vitality after being run over by a railroad car, and that such cases invariably necessitate amputation, Dr. H. Nye, of Enon Valley, Pa., reports the following interesting case in the Pittsburgh *Medical Journal*, for August:—

March 4, 1878, I was called to see a man, A. H., aet. 18, who, I was informed, had been run over by the cars. I found my patient lying on a lounge in the bar room of a hotel. He had a long heavy overcoat on which extended below the knees. He also had on a heavy lined pair of trowsers and overalls. Upon removing the clothing I found a fracture of the tibia and fibula through the thickest part of that bone, about two or three inches below the knee joint. I also found the flesh severely bruised on both lateral sides of the site of fracture. There was a good deal of oozing of venous blood, passive in character. There was no displacement of the fragments, and I could not discover that the bones were crushed or com-

minuted, or that the fracture or contusion extended into the joint. Upon inquiring how the accident occurred, I was informed that the man had got in the way of a *slowly* moving car without having noticed its approach till too late to get out of its way; that in trying to get out of its way he was thrown down and run over by the car, or rather that one wheel passed over his right leg just below the knee. It was noticed that the long overcoat he wore had got in some way wrapped around the leg over which passed the car wheel. The car stopped, or was stopped before another wheel passed over. Upon a careful consideration of the nature of the injury, the manner in which it occurred, and what to me was a weighty consideration, that the boy was in good condition, of good habits, sound constitution, plenty of grit, etc., I concluded to give him a chance to save his leg, even though it was at the peril of his life. I put the leg in a fracture box. I did not use extension, as there was no displacement, and I applied cold water dressings just as long as they were agreeable to his feelings. There was a good deal of traumatism for a few days, and in a week or ten days the parts over the site of the fracture that were so severely contused sloughed and came away, leaving a healthy granulating ulcer, which healed readily. I might here say that the hemorrhage from this contused part had been controlled by covering it with subsulphate of iron in powder, and then applying pressure by the hand over all; this may account for the ready healing of the wound On the 29th of March the boy was sent home to his parents. He made a rapid recovery without any shortening or deformity whatever.

A Case of Subacute Ovaritis.

The following clinical case is reported by Dr. A. W. Foot, in the Dublin *Journal of Medical Science*, August:—

A young girl (seventeen), Alice G., applied for advice, 28th May, with severe pain in the right iliac fossa, so sharp she "could hardly breathe," and interfering with her standing and walking. She had frequent sickness of stomach, no appetite, moderate fever. This pain had come on suddenly, without assignable reason, on the last day of a catamenial period. There was great tenderness over the right ovary. She was kept in bed, at rest, on her back, with poultices over the seat of pain, and given bromide of potassium (7½ grs. three times a day). In a week she got up, at her own request, but was weak, and unable to continue long out of bed at a time. She was now given some wine, and a mixture with tartarated iron. She went out well on the 6th June. This may have been merely ovarian hyperæsthesia, but it was also suggested to you that it might have been a case of subacute ovaritis, or of local peritonitis arising from the bursting of a Graafian vesicle into the cavity of the peritoneum. Hughes Bennett reports a case of peritonitis from this cause; the patient was admitted into the hospital on the sixth day, and died on the eleventh day. He adds that he has since seen three other cases of the same kind, all of which recovered. In none of these latter, he remarks, were leeches applied.

The Treatment of Typhoid Fever by Salicylate of Soda.

M. Caussidou made a communication to the meeting of the French Association for the advancement of Science at the Congress of Algiers, (London *Medical Record*) which was based on thirty-two cases of typhoid fever treated by salicylate of soda, and in which the rise of the temperature and the influence of this drug on the febrile process had been registered with the greatest care, as attested by numerous tracings shown by the writer. M. Caussidou arrived at the conclusion, in opposition to the facts observed in several wards of the Paris hospitals, that salicylated medication gives larger, more certain, and more permanent effects than refrigeration. M. Caussidou has even been in doubt if, by administering salicylate of soda from the outset of typhoid fever, it would not be possible to limit the duration of the disease to the first week (?), and if, at least, it would not be possible to obtain a number of cases belonging to the abortive form. Nevertheless, M. Caussidou does not conceal the dangers of salicylate medication. Like other observers, he has noted dyspnœa. præcordial trouble, and exhaustion in patients where the salicylate of soda has brought on a too sudden apyrexia. To avoid these objectionable results, he proposes to administer salicylate of soda in fractional doses of one gram given every two hours, and to stop so soon as the temperature falls below 38° Cent. (100.4° Fahr.) In a complicated case of erysipelas the salicylic medication was powerless to produce a febrile recrudescence brought on by this complication. M. Hérard declared that he had nothing but commendation for the use of antiseptics, such as carbolic and salicylic acids, in the treatment of febrile diseases.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——Among the pamphlets recently received are: A reprint from the *Annals of Anatomy and Surgery* for August, 1881, containing a paper on the "Surgical Anatomy of the Sheaths of the Palmar Tendons," by Dr. Rowell Park, of Chicago.

A reprint from the Transactions of the *American Neurological Association*, vol. ii, 1877, containing two valuable papers; the *first*, "A Clinical Contribution to the Study of Post Paralytic Chorea"; the *second*, "A Contribution to the Study of Localized Cerebral Lesions;" both by Dr. E. C. Seguin, of New York.

A reprint from the *Medical Record*, on "Tenotomy in the Treatment of Congenital Club-foot," by Dr. A. P. Morgan Vance, of New York.

"Glaucoma Caused by Mental Worry," from the Detroit *Lancet*, a paper by Dr. Leartus Conner, of Detroit, Mich., of which we have previously given an abstract.

A reprint from the Transactions of the American Medical Association, 1880, on a case of "Stenosis of the Larynx," with fibrous adhesive bands of the true vocal chords; tracheotomy, rupture of bands and cure of stenosis by general and local treatment. Also some remarks concerning the "Value of the Galvano-cautery in the Treatment of Diseases and Growths of the Naso-pharynx," by Dr. W. H. Daly.

"State Medicine; What has been Accomplished and what is Needed in Indiana," by Thaddeus M. Stevens, M.D., of Indianapolis, Ind., reprinted from the Transactions of the State Medical Society, 1881.

——Dr. DeForest Willard sends us, in a reprint from the Philadelphia *Medical Times*, a paper on "Hip Injuries, Including Hip-joint Diseases and Fractures of the Femoral Neck, with Splint for the same," and also a reprint from the Boston *Medical and Surgical Journal*, a report of a case of "Hip-joint Disease, with Death in the Early Stage, from Tubercular Meningitis," giving microscopic appearances, with cuts by Dr. E. O. Shakespeare.

——We have also received the "Ninth Annual Report of the Board of Managers of the Church Dispensary of Southwark," No. 1719 South Ninth Street, Philadelphia, with Charter and By-Laws.

——The *Indiana Medical Reporter*, which during the past year has frequently furnished us with valuable information, has now successfully passed through its infancy and has developed into a more cosmopolitan organ, under the new title of the *Western Medical Reporter*. It numbers among its editorial staff gentlemen from several States who, we have no doubt, will fill their promise of keeping it in the front rank of medical journalism. It is a monthly journal, published at the low price of $1.00 per annum.

——*The American Pulpit and Pew* is the title of a new religious paper, of which we have received the first two numbers. It is edited by the Rev. E. B. Raffensperger, of this city, and published monthly, at the price of 50 cents a year, or five cents per number. We have looked carefully through the advertising columns for quack advertisements, with which papers of that class are usually overflowing, and must confess how agreeably we were disappointed, when, beyond the notice of a certain electric battery, which is warranted to prevent and permanently cure almost every disease, we found nothing at which honest men need blush.

BOOK NOTICES.

Transactions of the South Carolina Medical Association, Thirty-first Annual Session, held in Newbury, S. C., April 19th, 20th and 21st, 1881. pp. 127.

Transactions of the Mississippi State Medical Association, Fourteenth Annual Session, held in Winona, April 6th, 7th and 8th, 1881. pp. 196.

Minutes of the State Medical Society of Arkansas, at its Sixth Annual Session, held at Little Rock, April 27th, 28th and 29th, 1881. pp. 48.

The address of Dr. B. W. Taylor, president of the South Carolina Medical Association, was on the "Hygiene of Infancy." It was carefully prepared, but nothing new on the subject was presented. Numerous papers on subjects of general interest were read. All of these were remarkable for their brevity, a characteristic which cannot be too highly praised. We have not the space to notice all of these; but will mention the following, which seem to us of special interest: Dr. F. F. Gary, of Abbeville, reported a case of acute chorea successfully treated with large doses of veratrum viride. Dr. Thos. J. M'Kie, of Edgefield, read a very interesting, and in every sense valuable, paper on the "Negro and some of his Diseases." The subjects of the other papers were of no less importance, but they were such as are more familiar to us all.

Dr. W. F. Hyer, president of the Mississippi State Medical Association, chose for the subject of his address the following motto from the Seal of the Medical Association of the State of Tennessee: "The Science of Medicine an Important Department of the Science of Humanity." The subject was well handled; among other things, the speaker pleaded for medical legislation, and impressed on his hearers the importance of agitating the matter until the passage of some law, no matter how imperfect, be accomplished. The Hon. J. S. Morris, of Vicksburg, read an address on the "Rights, Duties, and Responsibilities of Physicians before Courts"; The "Abortive Treatment of Pneumonia" was the subject of a paper by Dr. W. Y. Gadbury, of Yazoo City; "New Remedies," by Dr. B. A. Vaughan, of Columbus; "Diphtheria," by Dr. J. B. Gresham, of West Point; "Recent Advances in General Pathology," by Dr. B. F. Ward, of Winona; Dr. M. S. Craft, of Jackson, chairman of Committee on Surgery, presented a lengthy report upon the "Surgery of Mississippi." A new appliance for fracture of the lower extremities was exhibited and described by Dr. W. Y. Gadbury.

At the meeting of the State Medical Society of Arkansas, Dr. Lenow, of Little Rock, delivered the address of welcome, which was characterized by the usual eloquence displayed on such occasions. The president, Dr. William M. Lawrence, of Batesville, in his address, prayed that, when the Legislature next meets, the good Lord would deliver them from any act regulating the practice of medicine. The remainder of the volume is filled with Committee Reports and Resolutions. No papers were read.

Text Book of Modern Midwifery. By Rodney Glisan, M.D., Emeritus Professor of Obstetrics and Diseases of Women and Children, in the Medical Department of the Willamette University, and late President of the Oregon State Medical Society. With one hundred and thirty illustrations. Philadelphia: Presley Blakiston, 1012 Walnut street. 1881. 8vo, pp. 639. Price, cloth, $4.00; sheep, $5.00.

This work has been written with the object of producing a text-book which shall represent the obstetric art as practiced in America at the present day, and it owes its origin to the fact that existing works by American authors are more or less antiquated, so that students and practitioners in this country have had largely to depend on European text-books. The author introduces the subject with a brief review of the history of midwifery, and the changes in practice within the past twenty years, and then proceeds to discuss the anatomy and physiology of the female organs concerned in reproduction. The growth and development of the fœtus and the modes by which it derives its nourishment, are next considered. Many of the purely theoretical questions the author deals with by presenting the views held by various authorities, without definitely committing himself to one or the other. The more practical portion of the work, embracing the diagnosis of pregnancy and the management of labor, as well as the after treatment, is stamped with the same spirit of moderation. On the vexed questions of to-day, the use of the forceps, anæsthetics, etc., he commits himself to neither extreme. He regards the forceps as one of the most valuable of instruments and even advocates their introduction into the cavity of the uterus in some cases; yet he thinks that the tendency now is toward their too frequent employment.

With regard to anæsthetics, he advocates their moderate use, especially in the second stage of labor, but thinks that they should rarely be pushed beyond easing the pains sufficiently to make them endurable, and where these are not very severe, anæsthetics should be dispensed with altogether. Chloroform, or a mixture of chloroform with ether or alcohol, he regards as the best agent, unless it be desirable to produce complete anæsthesia, when he thinks that ether had better be used, on account of the supposed paralyzing effect of chloroform on the heart's action. He also mentions other agents, as bichloride of methylene, hydrobromic ether, etc., but does not think them in any way superior to those ordinarily in use. The work, which shows evidence of extensive reading on the part of its author, is characterized throughout by its simplicity of style and the excellency of its precepts, coupled with modesty of expression. In vain do we look for the enthusiasm of the hobby-rider, which, no matter how interesting to read, is out of place in a text-book for students.

Chemical Analysis of the Urine. Based in part on Casselmann's Analyse des Harns. By Edgar F. Smith, PH.D., Asa Packer Professor of Chemistry in Muhlenberg College, and John Marshall, M.D., Demonstrator of Chemistry, Medical Department, University of Penna. With Illustrations. Philadelphia: Presley Blakiston, 1012 Walnut street. 1881. Cloth, 12mo, pp. 104. Price $1.00.

With the excellent works on urine analysis already in existence, we had hardly expected to see anything new for some time. Notwithstanding this the present treatise has its claims on the profession, and is intended by its author to fill a *gap*. The chief characteristics which recommend it are, *first*, brevity, and *second*, more attention to the chemical side of the question than is usually found in similar treatises. While it can never supersede such works as *Tyson's* and others, it certainly will aid the student in performing *understandingly* and with accuracy the principal analyses called for in practice. It is an admirable hand-book for laboratory work. The authors have introduced the decimal system of weights and measures, as well as the Centigrade scale of thermometer.

Cyclopædia of the Practice of Medicine. Edited by Dr. H. Von Ziemssen, Professor of Clinical Medicine in Munich, Bavaria. Vol. xx. General Index. New York: William Wood and Company, 27 Great Jones Street. 1881. Leather. 8vo. pp. 499.

This volume contains a complete index of subjects, authors, etc., in the preceding volumes, referring the reader in each case to the volume and page, and thus by the use of this general index much time may be saved.

THE

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THE DEATH OF OUR LATE PRESIDENT.

A thrill of grief unprecedented in the annals of our country passed through our land when it was announced that the long struggle for life had ceased and that the suffering patient was no more. Prepared, as every one was, for this sad termination, it nevertheless came with the force of an unexpected shock, and few there were who did not feel as if some one near to them in friendship or kinship had been summoned into that invisible world which forever surrounds us.

Now that we can look back, with full knowledge of the lesion, on the treatment pursued, we must agree, whether planned with wisdom or partly governed by circumstances, it was, on the whole, as judicious as it could have been. A gunshot wound of the character caused by the assassin's bullet is, in a person of President Garfield's age, necessarily fatal; at least, the favorable chances are so infinitely small that it was to all intents and purposes a fatal wound, and the most that can be asked of surgery in such a case is to relieve suffering and prolong life for a little.

There is no doubt but that the results of the post-mortem, which we give on another page, as reported in the daily papers, pending a more detailed account, were a surprise to the public and to several if not all of the attending surgeons. Probably had the facts been known the treatment would not have been much modified. It seems to have been as suitable as, on reviewing it, one could well designate.

The autopsy contains in its development a severe rebuke for those who, on the one side, being in daily attendance on the patient, so confidently and frequently insisted that he would certainly recover, that there was no pyæmia, etc., etc.; and, on the other side, for those surgeons who, not being in attendance, and never having seen the case, criticised the treatment in the daily papers, and were so ready with suggestions and animadversions, all of which, we now see, were uncalled for and out of place. The desire to rush into notoriety was at the bottom of both these exhibitions of imprudence, and doubtless those who committed them have already regretted their hasty actions. Among the many lessons of the case, this, too, may be of use for future guidance.

NOTES AND COMMENTS.

Vaccination in Malignant Charbon.

The recent experiments of M. Pasteur and other French savants on the virus obtained from sheep suffering from malignant charbon have led to very remarkable results.

By culture of the bacteriæ obtained from this virus, M. Pasteur has succeeded finally in procuring an attenuated virus, with which, he asserted, sheep might be inoculated with impunity and rendered incapable of contracting the malignant disease. These assertions were recently put to the proof, before a special commission named by the prefect of one of the departments where the disease is common. Nineteen sheep were primarily vaccinated with M. Pasteur's attenuated virus, and later on were inoculated with virus taken from a sheep which had succumbed to the malignant disease; at the same time sixteen sheep were taken from the flock and inoculated with the same virus.

The results were completely in accordance with those obtained by M. Pasteur in his experi-

ments; three days after the inoculation fifteen of the unvaccinated sheep were dead, while the nineteen which had been vaccinated were perfectly well and had not presented any morbid symptoms.

These experiments at Chartres thus absolutely confirm those at Melun; many farmers from the neighboring district watched the experiment with interest, and several desired to have their flocks vaccinated, to preserve them from the disease which has proved a scourge in several departments.

Treatment of Gonorrhœa.

In a recent work, M. Bourgeois strongly recommends the following injection, after the painful period has passed:—

℞. Potass. permanganat., gr. j
Aquæ destill., ℥v. M.

This solution is apt to stain the linen, which renders its use somewhat inconvenient.

Capsules containing only the resin of copabia were recently exhibited at the Societé de Thérapeutique. The idea of this treatment originated with Gubler, who asserted that it was the resin alone which was eliminated by the kidneys, and had any curative effect in gonorrhœa; while the volatile oil eliminated by the lungs gave the odor of the balsam to the breath, and induced the skin eruption.

During the discussion, M. Constantin Paul spoke very favorably of the extract of cubebs, by which alone the drug might be administered in large doses, which sometimes prove successful in checking the disease at its debut.

Chloroform Inhalation in Stramonium Poisoning.

A correspondent of the *Lancet* gives the following interesting case:—

In the latter part of last year, at midnight, I received a very pressing call. At the midday meal a family had partaken of a dish of boiled stramonium leaves, in mistake for greens. The parents and one child, who had soon discovered their mistake, were not very seriously affected; but the son, aged eight, having eaten a considerable quantity, quickly showed dangerous symptoms, and, although he vomited shortly afterwards, became wildly delirious. When I arrived the boy had been in this state eleven hours and a half, and seemed to grow worse.

The action of chloroform appears to be antagonistic to that of the deliriants. Professor Schäfer has recommended the use of atropia during the inhalation of chloroform. Bearing this in mind, I determined to try chloroform inhalation in this case. The result exceeded my expectations. In a few seconds the boy became quieter, roused himself to vomit about a handful of dark green leaves, then again became quiet. His face regained its normal tint, and in five minutes he appeared to be in a natural slumber.

The boy slept thus through the night and got up to his breakfast quite recovered.

Inhalation of Cold Air in the Treatment of Pneumonia.

Dr. J. Turner Everett, of Sandusky, O., states, in a communication to the New York *Medical Record*, Sept. 10th, 1881, that the continuous inhalation of cold air, ranging from 10° to 15° Fah., while the patient is kept in a room with a temperature of from 80° to 85° Fah., will, in the early stage of pneumonia, act as an abortive, and bring the disease to a speedy termination. His explanation is, that the cold air, coming in direct contact with the tissues of the pulmonic parenchyma, abstract heat from the blood, and by carefully noting the external temperature and that of the patient, this abstraction of heat can be regulated with the utmost nicety and precision—can be commenced or stopped instantly, without prostrating the nervous system by sedatives or narcotics, and without the loss of blood.

This cold air in thus coming in contact with the lung tissues causes contraction of the vessels, thus lessening the amount of blood admitted to the lung tissues, and by its constringing influence tends to drive out that which has become partially deposited by the stasis, while by increasing the oxygenation of that already admitted it hastens resolution. The increased heat of the air surrounding the patient favors copious perspiration, thus, by the evaporative process, favoring the additional abstraction of heat.

In winter, when the atmosphere out-doors is cold, he causes the patient to breathe through a rubber tube, one end of which is inserted through a hole in the window sash, while the other end, fitted with a proper face piece, is given to the patient. In treating a few cases that might occur in the summer, the air should be drawn through a refrigerator. The history of eight cases are given, all of which recovered rapidly.

The Medicinal Use of the Tomato.

Dr. T. K. Griffith, of Hollyrood, Kansas, has found the tomato, eaten raw, or in the form of a fluid extract prepared from the fruit without the use of heat, a very valuable remedy in the treatment of nurse's sore mouth and "canker." In

the *Therapeutic Gazette*, for September, 1881, he states that in the summer of 1874 he was treating a case of nurse's sore mouth with chlorate of potassa, carbolic acid and glycerine, iron, quinine, etc. When the earliest ripe tomatoes of the season came into market, the patient saw them, and craved them as food. He directed that she be allowed some; she ate some, and continued to crave them, which craving he allowed her to satisfy. There was a marked improvement in the case from this time; the mouth healed, the appetite returned, and the patient gained strength. Since then he has employed the tomato in a large number of cases, and always with the same success.

Ergot and Bromide of Potassium in the Treatment of Sea Sickness.

Dr. T. S. Hopkins, of Thomasville, Ga., recommends, in the Atlanta *Medical Register*, for October, 1881, the following prescription, which he has found very successful:—

℞. Potassii bromidi,
Ext. ergotæ, fl., (Squibb) āā ℥ ss
Aquæ, ad ℥ vj. M.

Sig.—Tablespoonful; repeated, if necessary, three times daily.

He was induced to try this combination because of the well known power of ergot to contract the arteries, and because the bromide alone had always failed him. He says that it is preventive as well as curative. Ergot was suggested by Professor W. S. Haines, of Chicago (in a private conversation with a medical friend), in 1874, on theoretical principles.

Oakum in Affections of the Joints.

M. Constantin Paul, at the Hospital Lariboisière, has been employing oakum with great success in the treatment of subacute and chronic affections of the joints. It is simply wrapped round the painful joints, to the thickness of one-half to one inch, and left there. He found it especially useful in gonorrhœal arthritis of the knee, in arthritis deformans, and in all cases where the application of iodine is usually recommended.

Hypertrophy of the Spleen in Children.

Dr. Bouchut, in a clinical lecture at the Hôpital des Enfants Malades, on hypertrophy of the spleen, due to palustral influences, and not amenable to ordinary treatment, referred to three cases, one of four years of age, another of two, and a third of ten, which presented enormous spleens, forming tumors, and inducing aneurism, leucocythæmia, and the cachectic condition, so difficult of removal. Quinine, arsenic, cold douches over the region of the spleen, had all been employed without success. Splenotomy had not been performed on any of them, but in Dr. Bouchut's opinion this operation is the only resource when ordinary therapeutic agents are without avail, and the patients would otherwise rapidly arrive at the fatal end.

Leucorrhœa in Children.

M. Bouchut recommends the following method of treatment in the leucorrhœa sometimes observed in young children:—

1st. Frequent lotions of the parts with bran water, Goulard's solution or infusion of oak leaves.

2d. Touch the vulvo-vaginal mucous membrane with the following solution:—

℞. Hydrarg. bichlorid., 10 centigrs.
Aq. destill., 300 grams. M.

or with

℞. Argent. nitrat., 20 centigrs.
Aq. destill., 30 grams. M.

And place between the labiæ majoræ, charpie wetted in antiseptic solutions.

3d. Administer tonics, reconstituents and the remedies proper for any diathesic disease that may exist.

Treatment of Chronic Bronchitis by Cauterization.

Dr. Barth publishes, in *La France Médicale*, a remarkable case of recovery under this treatment, which he believes will be successful under similar conditions. A young woman had a chronic bronchitis, the sequel of an acute attack three years before. The usual remedies had been tried in vain, when M. Barth had recourse to the idea of making slight punctures by the thermocautère over the thoracic walls. The whole back was thus covered with small spots of cauterization. On the next day the dyspnœa was markedly less. Three days afterwards there was a second application, attended by further improvement; there were altogether six cauterizations, and in four weeks the patient was discharged cured.

Action of Digitalis Preparations.

Some experiments published by Dr. Fränkel in the *Annalen des Charité Hospitals*, give the following results: 1st. The tincture, and also the acetum and the infusion of digitalis, are capable of exercising and exciting influence upon the inhibitory nerves of the heart, and

upon the vaso-motor centre; but there are unmistakable grades of distinction in the action of the three preparations. 2d. The tincture is the least reliable. 3d. The action of digitalis—retarding of the pulse and increased blood-pressure setting in, after divers large doses of both the infusion and the acetum—sets in according to the individuality of the animals, and other accessory circumstances. 4th. The acetum digitalis is the most powerful.

Special Reports.

NO. XVII.—THE LAWS OF MALPRACTICE.

The questions of how far and under what circumstances a medical man is amenable to the laws of malpractice have for every practitioner not only a professional but likewise a personal interest, for he knows not how soon he shall have to face a jury, and be compelled to defend the course he has pursued in the treatment of any given case. As a general rule, questions of malpractice rarely arise in the province of medicine, pure and simple; the surgeon is, as a rule, more apt to be made to feel the sting of the law's lash than his brother who eschews the knife and seldom deals with splints; still there are occasions when even the general practitioner may be placed in the unenviable situation of defendant in a malpractice suit, or the victim of unacquaintance with some of the laws which government has seen fit to hedge him around about with. A knowledge of a number of decisions which have recently been rendered by the courts of three or four of the different commonwealths, in some cases the superior courts rendering the judgments, should be disseminated throughout the ranks of the profession, in order that each may know when he is liable and when not liable for damages.

An interesting question has arisen lately in this city (Philadelphia) as to when a physician may issue his certificate of death, and when he will be debarred from using the privilege which the law confers upon him. The law, in its wisdom, at least, so far as this State is concerned, puts a limit to the time within which a doctor must have seen an individual in life, in order that his certificate shall properly and legally cover that individual's death and burial. That such a law is a necessity is evident to every thinking man in the community, for it undoubtedly affords a means of protection for the living against the perpetration of secret crimes, and tends to lead to their detection by increasing the number of checks upon all concerned in the interment of dead bodies; either owing to a lack of knowledge of the provisions of the law, or to a misunderstanding of its meaning, one may unwittingly bring himself into the unpleasant predicament of having to learn the full force and meaning of the old maxim, "that ignorance of the law excuses no man." On the twenty-second day of March, 1867, the State Assembly passed a law entitled "A law for the guidance of physicians in returning deaths to the Coroner" which law reads as follows:—

"It shall be the duty of the Coroner of the city and county of Philadelphia to hold an inquest on the body of any deceased person who shall have died a violent death, or whose death shall be sudden, Provided, that such sudden death be after an illness of less than twenty-four hours' duration, and that no regular practicing physician shall have been in attendance within said time, or that suspicious circumstances render the same necessary, which said suspicious circumstances shall first be sworn to by one or more citizens of said city. Violent deaths include homicide, deaths from criminal abortion, infanticide, suicide, deaths *from any kind of accident*, such as injuries from being run over in the street, from machinery, from falls, burns, scalds, accidental poisoning or drowning. In any of the above or like cases it is the duty of the physician to refuse to give a certificate of death, and the Coroner should at once be notified. Any physician violating the provisions of this act of General Assembly shall be fined in a sum not exceeding £100."

Now one or two interesting questions may arise under this law: the act provides that if the death happens within twenty-fours from the time of the onset of the disease, accident or what not, and that no regular physician has been in attendance, then and in that case report must be made at once to the Coroner; but, by construction, the law also goes further; it is not sufficient only that the case shall have been seen twenty-four hours before death, but that if the slightest suspicious circumstance surrounds the death it is a coroner's case. Again, according to the practice of the coroner's office in Philadelphia, where a physician is called within twenty-four hours of the time of death, it being his first visit to the patient, or the first after a prolonged interval, and finds him suffering from a chronic trouble (such as phthisis, etc.) of which he dies within the specified time, no matter whether there be suspicious circumstances or not, it is his duty to report such death to the coroner, and receive the permission of that officer before issuing his certificate of death. Now, supposing that the doctor has been in attendance during a prolonged period, seeing the patient off and on, say every few days, or every week or ten days, and the case dies in the interim between the usual visits, shall a certificate be

issued? the law says yes, unless, in the good judgment of the attending physician, an investigation of the cause of death should be made.

An interesting case coming under this last proviso is still fresh in the recollection of the community: A physician being summoned three days or more before death, to attend a sick person, having at infrequent intervals seen the deceased previous to that time, was called on to issue his certificate for the burial of the person, who had died at the end of the thirty days, of what purported to be inflammation of the stomach. Now the doctor had known the lady and her family for many years, and while no particularly satisfactory cause could be assigned for the inflamed stomach, etc., with which he had to deal, yet no suspicion arose in his mind that foul play either had been or was contemplated. The woman died, and the necessary papers having been demanded they were issued by the doctor, thus permitting of the burial of the corpse. Some days after interment suspicions arose that all was not clear and above-board, in regard to the deceased's death, and an investigation was prompted. This was made, the body being disinterred for the purpose, when it was demonstrated that, beyond the shadow of a doubt, death had been caused by an irritant poison, which must almost necessarily, from surrounding circumstances, have been administered to her by some of the family, and which subsequently proved to be the case. Here the question of the exercise of sound and discreet judgment comes in as a factor in the issuance of a certificate; in a case of this nature, where such a viscus as the stomach, which, as a rule, is not the seat of idiopathic inflammations, suddenly takes on an acute inflammation, the cause of which is extremely uncertain to the attendant, and the case dies, although the law authorizes him to issue his certificate, the good judgment of the physician should prompt him to insist upon an investigation, not only as a protection to the community, but also to himself, for he is very likely to be held strictly accountable, if not criminally involved, if, as in the case above spoken of, it should afterwards eventuate that a criminal conspiracy and murder had been perpetrated, and nearly hidden by reason of the facility with which his certificate had been obtained. But under ordinary circumstances and diseases one is warranted in issuing a certificate after two or three days' illness, for it is not an infrequent occurrence for death to take place, in acute troubles, within this period.

One would not, however, be justified in issuing a certificate, even though he should know the man to have been the victim of a chronic trouble that must sooner or later necessarily kill him, when such patient has not been seen within a reasonable period; thus a case dying that had not been seen for two weeks, a month, three or six months, would not be a fit case for the issuance of a certificate; it would be decidedly a coroner's case, no matter how certain the physician was of entirely fair play having taken place. The law further holds that the doctor must exercise a reasonable degree of care in specifiying the party whose death his certificate is supposed to cover, his proper name, residence, etc.

These two facts may often, in after years, be of great importance in litigation, etc., that may arise, when those who were qualified to speak may have disappeared from the scene, and it may be necessary to identify a party and prove his death at a certain time and place; although it is not so particularly from this view that the law demands exactitude, as from the fact that a certificate certifying to the death of a person in one section of the city might, if this care were not taken, be made to do duty for a person of the same name in an entirely different portion of the city or country.

To sum up this whole question of jurisprudence, we may say that a case should be referred to the coroner whenever—First, death has taken place within twenty-four hours of the first visit of the physician. Secondly, whenever, no matter what period has elapsed since the first visit, death takes place under circumstances of even the slightest suspicion. Thirdly, when death takes place when a long interval has elapsed between the last visit and the one immediately preceding the person's death. Fourthly, when, in the good judgment of the physician, an investigation of the cause of death should be made previous to interment; this provision would cover those cases where the survivors are greatly interested in the death of the patient, and hope thereby to reap benefit.

Of course the law on this subject would permit of a much more extended discussion, but the space of a magazine article does not permit of such a thing. The main features, however, governing the profession, I think, are shown in this résumé of the matter.

Another interesting question in the field of medical jurisprudence, and one which, unfortunately, is largely overlooked, both in the books and general literature, is that of the increase of responsibility of physicians and surgeons in their treatment of cases, how far, when, and under

what circumstances they are liable in damages, and whether under like circumstances they are all equally liable. The courts hold that a surgeon or physician must possess such a degree of general knowledge as the advanced position of the medical profession demands, frequently only theoretically, that he should have. They further hold that he must excercise a due amount of care and attention in the treatment of his patient, and that his negligence, either in attendance or treatment, shall not be the cause of any after inconvenience to, or physical disability of, his patient; at the same time, the court would hold, in equity and justness, that the patient must contribute, so far as in him lies, to the assistance of the medical attendant, and to the observation of a due and faithful attendance and carrying out of the directions of the physician, and that he must not intentionally, in any way interfere with the means adopted for his relief, unless, of course, it be evident to any one that a wrong course is being pursued, that shall inevitably result in disaster if persisted in, though even then it is a question whether the proper course for the patient to take would not be to insist upon a consultation with some surgeon or physician of his own selection, for what at times may seem entirely wrong to the non-professional eye, may perhaps be a perfectly proper course to be pursued.

(To be continued.)

CORRESPONDENCE.

Case of Intussusception of the Bowels Relieved by the Injection of Cold Water.

ED. MED. AND SURG. REPORTER:—

The following case of invaginismus of the bowels, which occurred in my practice two years ago, I feel to be a duty to report to the profession through the columns of the REPORTER. Mrs. L., aged forty, residing six miles from the city, was taken, in the night of September 13th, with severe cramps in the bowels, accompanied with retching and vomiting. Doctor Heist, the family physician, was called in the morning to visit her. Not suspecting the true nature of the case he had to treat, he prescribed calomel and opium, etc., for the relief of his patient. Upon his next visit he found the patient no better, and vomiting stercoraceous matter, which at once convinced him that he had an obstruction of the bowels to deal with. The usual remedies in such cases were resorted to, together with frequent enema of different kinds, but all without affording the patient any relief. The retching and vomiting continued, preceded with severe pain in the bowels. The stomach would no longer retain anything administered, and hypodermic injections of morphine were resorted to, to render the patient as comfortable as possible.

On the fifth day after the attack two physicians from a neighboring town were called in consultation, who, after learning the nature of the case and the treatment of the attending physician, left without prescribing. The woman, having a good constitution and previous good health, continued to live, beyond all expectations. On the ninth day of her illness I was sent for in consultation. The doctor remarked, as I was an "old doctor," I might know something more than he had done, and if not, would satisfy the friends that his treatment had been proper. I found the patient rational and fully aware of her dangerous condition; she was very much prostrated; pulse 130, respirations frequent; the breath very offensive; the surface cool, with clammy sweat; and she as well as her physician convinced that she could not survive till morning if not relieved. Having, some six months previous, met with a case of strangulated hernia in a man, which I succeeded in reducing by the introduction of a large piece of ice into the rectum and the application of cold to the hernial tumor, I concluded to try the injection of cold water, as a last resort, hoping that thereby the obstruction might be overcome.

Having no ice at my command, I ordered cold water brought from the well. I laid the patient upon her right side, with the hips elevated and the body and head inclining downward. With a large-sized Mattson syringe, after introducing the long tube as far as I could, and having an assistant with a cloth applied to the anus to maintain pressure and prevent the return of the water, I pumped, with considerable force, about three pints into the bowels. The patient retained her position about ten minutes, the compress being maintained, when she expressed a desire to get upon the chamber; she was assisted up. The water passed away with a small quantity of fecal matter. She again resumed the same position, and in fifteen minutes had another passage of thin, watery excrement; in half an hour afterward she had another passage, of nearly natural fæces; she was then given some thin gruel, which the stomach retained. I left the patient in the care of her physician, feeling assured that all would end well.

The following day her husband came to the city and reported that after I left she took more nourishment, and the doctor gave her an opiate, upon which she rested well all night, and in the morning was cheerful and rapidly recovering. I have met in my practice several cases of intussusception of the bowels, all of which proved fatal, except this one. Should I meet with another case I would resort to the cold water injections with good hopes of success. A. GEIGER, M.D.

Dayton, O.

Maternal Impressions.

ED. MED. AND SURG. REPORTER:—

Under the above heading we have had quite a number of articles lately to prove that the mental in the mother sometimes shapes the physical in the child. But it occurs to me the writers have taken effect for cause. I venture the assertion, that there is not an intelligent woman in the world who goes through the allotted period of gestation without having "impressions." They

have "longings" and many other both mental and physical peculiarities, yet no one thinks of placing these in the light of "cause." After having many impressions while waiting, and thinking, and planning, and dreading, it is scarcely possible to produce an abnormality or monstrosity to which none of these impressions will apply. The impression *never* (I believe I can safely say never) takes positive, definite shape, until the mother sees which one of her impressions is most nearly produced. Then all the others fade away, and the outlines of that which comes nearest are studied, and rehearsed, and mended, till the poor mother imagines, and the doctor helps her believe, that a mark was placed upon her unborn babe through the workings of her own disturbed, perverted and often really diseased mind.

Sometimes she will forget all about it, and blame the doctor for scarring her offspring with his instruments, until, at his suggestion, she searches for an "impression," and in a few days remembers that one day during those nine long months of waiting she rubbed her eye, and so deprived her child, in its unborn innocency, of both perfect vision and natural symmetry of form; or after admiring the red-headed brother-in-law's hair more than her husband's impressed *that* on her babe.

If the almost infinitely small sperm of the male zebra had a sufficiency to maintain itself throughout the period of the mare's gestation in the first instance, why may we not suppose the blood which was uninterrup'edly mingling through the fœtal and maternal hearts retained sufficient of that which produced the stripes on the first to reproduce them on the second, though the second sperm was produced by one of the mare's own kind, and all the other parts were after that kind.

Bannerville, Pa. ISAAC R. SWIGART, M.D.

Incontinence of Urine.

ED. MED. AND SURG. REPORTER:—

On thinking over the subject of incontinence of urine, the following plan of treatment has suggested itself to my mind as likely to prove successful, especially in those cases in which this very annoying and obstinate complaint is the result of, or is kept up by, habit.

Attach one pole of an electric battery to a *moist* sponge, or metallic plate, fastened between the shoulders of the patient, and the other to a *dry* sponge placed over the meatus urinarius. When this has been done and arranged so as not to annoy the patient, let him be put to bed and the circuit of the battery completed. The sound of the battery will soon lull the patient to sleep. While the sponge is *dry*, no electricity passes through the body of the patient and his slumber is undisturbed, but the moment the patient begins to urinate the sponge is moistened, it becomes a conductor of electricity, a circuit is completed through the body of the patient, and he or she is at once aroused, awakened, caught in the very act, and thus a caveat is entered by the will of the patient, as well as by the electricity, against further proceedings, at least for this time. A repetition of a like experience for a sufficient number of times ought, I am inclined to think, to cure the patient; but since this suggestion has occurred to me I have not had an opportunity of putting it to the test of practical experiment, and submit it to the consideration of the profession for what it is worth.

H. NYE, M.D.

Enon Valley, Pa., September 11th, 1881.

Periodic Headache, Due to Nocturnal Epilepsy.

ED. MED. AND SURG. REPORTER:—

I enclose notes of the following case:—

J. B., æt. thirty, height five feet six inches; a well-made man; dark complexioned, slightly inclined to corpulence. His wife informed me that every Monday he awoke with a headache, so severe as to incapacitate him from attending to his business. The headache never came except on Monday. It wore off in the course of the day, and was gone by Tuesday morning. There was no malaria prevalent at that time and place to account for these distinctly periodic attacks. On further inquiry, I found that he invariably had the "nightmare" on Sunday nights; the spells beginning with a cry, and not lasting over five minutes. No scars were to be found upon his tongue. His eyes had that peculiar look frequently seen in epileptics, though by no means confined exclusively to them. The diagnosis of nocturnal epilepsy was subsequently confirmed in a singular manner. For some urethral difficulty, I attempted to introduce the nozzle of a syringe; but no sooner did the instrument touch the meatus than he went into an epileptic fit; beginning with a scream, in the course of which both bowels and bladder were evacuated.

Thinking there might be some reason for the fits appearing only on Sunday nights, I inquired as to what peculiarity there was in his habits of the previous day. He informed me that he ate over a quarter of a pound of Swiss cheese every Sunday evening, generally about 11 P.M.

Abstinence from this article, regulation of his habits in some other respects, and the use of bromide potassium in forty-grain doses, three to six times daily, were followed by a rapid cure, which has now endured for more than a year.

WM. F. WAUGH, M.D.

878 *North Sixth street, Philadelphia.*

Enlarged Spleen.

ED. MED. AND SURG. REPORTER:—

In your valuable journal, recently, I have noticed several articles on treatment of enlarged spleen. Large practice in a district where all forms of malarial diseases are met with necessarily affords a vast field for observation, as enlargement of the spleen is a usual concomitant of chronic intermittents. A few weeks since I was called upon to prescribe for a case of greatly hypertrophied spleen of over a year's standing; so tender that the ordinary movements of the body sometimes caused excruciating pain. Ordered hydrarg. iodid., rubri ung., one drachm, to be rubbed over the region of the spleen every other

night. Through mistake it was rubbed over the whole side. A few days after it was reduced in size to almost normal, all soreness had disappeared. I have treated a great many cases of chronic enlargement of the spleen, and have never found it necessary to use any other remedy, as the results attending its use have been eminently satisfactory in my hands as well as in the hands of others, to whom I have recommended it.

H. K. HILLER, M.D.

Hookerville, Texas.

NEWS AND MISCELLANY.

The Autopsy of the Late President Garfield.

The following is the official report of the autopsy of the late President:—

ELBERON, Sept. 20th, 1881.

By previous arrangement a post-mortem examination of the body of President Garfield was made this afternoon, in the presence and with the assistance of Drs. Hamilton, Agnew, Bliss, Barnes, Woodward, Reyburn, Andrew H. Smith, of Elberon, and Acting Assistant Surgeon D. S. Lamb, of the Army Medical Museum, Washington. The operation was performed by Dr. Lamb. It was found that the ball, after fracturing the right eleventh rib, had passed through the spinal column, in front of the spinal canal, fracturing the body of the first lumbar vertebra, driving a number of small fragments of bone into the adjacent soft parts, and lodging below the pancreas, about two inches and a half to the left of the spine and behind the peritoneum, where it had become completely encysted. The immediate cause of death was secondary hemorrhage from one of the mesenteric arteries adjoining the track of the ball, the blood rupturing the peritoneum, and nearly a pint escaping into the abdominal cavity. This hemorrhage is believed to have been the cause of the severe pain in the lower part of the chest complained of just before death. An abscess cavity, six inches by four in dimensions, was found in the vicinity of the gall bladder, between the liver and the transverse colon, which were strongly adherent. It did not involve the substance of the liver, and no communication was found between it and the wound. A long suppurating channel extended from the external wound, between the loin muscles and the right kidney, almost to the right groin. This channel, now known to be due to the burrowing of pus from the wound, was supposed during life to have been the track of the ball. On an examination of the organs of the chest evidences of severe bronchitis were found on both sides, with broncho-pneumonia of the lower portions of the right lung, and, though to a much less extent, of the left. The lungs contained no abscesses and the heart no clots. The liver was enlarged and fatty, but free from abscesses, nor were any found in any other organ except the left kidney, which contained, near its surface, a small abscess about one-third of an inch in diameter.

In reviewing the history of the case in connection with the autopsy, it is quite evident that the different suppurating surfaces, and especially the fractured spongy tissue of the vertebra, furnish a sufficient explanation of the septic condition which existed.

D. W. BLISS,
J. K. BARNES,
J. K. WOODWARD,
ROBERT REYBURN,
FRANK H. HAMILTON,
D. HAYES AGNEW,
ANDREW H. SMITH,
D. S. LAMB.

Statistics of Female Physicians.

The Health Department of the Social Science Association, met in Saratoga, Sept. 6th, Dr. Walter Channing, of Boston, in the chair. Drs. Emily Pope and Mary Putnam Jacobi, were among the newly elected members.

Dr. Emily Pope read a paper on "The Practice of Medicine by Women in the United States." The objects were to show to what extent women were practicing medicine in this country; whether the majority of women graduates in medicine devote themselves to its practice; how far their pecuniary success shows a demand on the part of the public for educating women physicians; what effect the strain of practice has upon their health; what proportion of them marry, and with what results to their professional career.

The 470 circulars sent out to women physicians have brought statistics showing that 390 are engaged in active practice; 11 never practice; 29 have retired after practicing, 12 of whom after marriage; 7 retired from ill health, and 5 have taken up other work. These women are in 26 States, New York, Massachusetts and Pennsylvania having the largest proportion. Of those heard from, 75 per cent. were single when they began the study; 19 per cent. were married, and 6 per cent. widows. Average age when they began the study, 27 years; 144 practiced less than 6 years; 123 between 5 and 10 years; 40 from 10 to 15 years; 15 from 15 to 20 years; 23 over 20 years; 341 practiced regular medicine; 13 homœopathy; 10 gave no answer; 77 report that they supported themselves from the beginning of their practice; 34 in less than one year; 57 after the first year; 34 in two years; 14 in three years; 10 in various periods over three years; 138 say their incomes are still insufficient or make no reply; 12 never practiced; 20 are in hospital practice; 30 are not dependent on professional income; only 11 are left who can fairly be said to have practiced over two years without supporting themselves.

On the Diagnosis and Treatment of Guiteau's Insanity.

The editor of the *Arkansaw Doctor*, in a recent editorial on the mental condition of Guiteau, expresses himself as follows:—

The affection is one of nervous origin, and although the principal functional lesion is in the great nervous centre, the brain, yet like all nervous diseases it may have an anatomical lesion, remote from the functional, and the symptoms, (the aberration) are perhaps only reflex.

The history of the patient under consideration is such as to lead one to suppose that the primary lesion is situated in or upon the cervical portion

of the spinal cord, the history of Guiteau being that he had a tendency to put himself forward, or in other words that he had a mania for seeking a position inconsistent with his general qualifications. This, in country parlance, is known as "stiff neck," hence our location of the lesion in the cervical portion of the spinal cord.

Now, since nerve stretching has attained such popularity and recognition from eminent neurologists all over the world, we would modestly suggest a trial of this operation in Guiteau's case; although our knowledge of the operation is altogether theoretical, we would suggest the stretching of the cervical portion of the spinal cord, say about two inches. This, in our opinion, would produce an equilibrium in the nervous system.

This is not, as some might naturally suppose, a dangerous operation; we remember to have seen it performed on several occasions, by operators no better skilled in surgical science than the average sheriff, and we cannot recall a single failure.

More About Birth Marks.

The *Ohio Medical Journal* has the following good story, as told of a physician of Dayton, Ohio: The doctor was recently attending a case of labor in the family of one of his patrons, who, though a very excellent man, is a little slow in the payment of his medical bills. Immediately after the birth of the baby, the father nervously asked, "Doctor, is the baby marked?" "Yes," quietly replied the doctor, "It is marked 'C.O.D.'"

It is needless to add that the bill for that baby was promptly settled.

Prize Essay.

The committee of selection appointed by the chairman of the Section on Practical Medicine, Materia Medica and Physiology, at the recent meeting of the American Medical Association, have selected, and hereby announce, as the subject for the prize to be awarded in 1883, the following question:—

What are the special modes of action, or therapeutic effects upon the human system, of water, quinia, and salicylic acid, when used as antipyretics in the treatment of disease? The essays must be founded on original experimental and clinical observations, and must be presented to the chairman of the committee of *award* on or before the first day of January, 1883.

N. S. Davis,
H. D. Holton,
W. B. Ulrich,
} *Com. of Selection.*

Florida Medical Association.

At a called meeting of the Florida Medical Association, at Tallahassee, January 13th, 1881, the following officers were elected: Dr. G. W. Betton, Tallahassee, President; Dr. A. J. Wakefield, Jacksonville, 1st Vice President; Dr. J. M. Jackson, Bronson, 2d Vice President; Dr. A. L. Randolph, Tallahassee, Secretary; Dr. J. D. Fernandez, Jacksonville, Treasurer; Dr. A. W. Knight, Jacksonville, Librarian; Dr. R. B. S. Hargis, Pensacola, Orator. The association will meet in annual session, on the third Tuesday in April, 1882, at Pensacola. According to an act of the last Legislature of Florida, 1880–81. every city and town in the State having over three hundred inhabitants should have a Board of Health, consisting of seven members, one, at least, of whom should be a physician.

The Origin of Goitre.

The Geographical Distribution of Goitre in England has been studied by Professor Lebour. One important point only he considers to be established as common to those rocks on which goitre does not occur—the absence of limestone, together with that of metallic impurities. In this respect his results agree with those of Dr. de St. Lager, of Lyons, who has investigated the occurrence of the disease in France. In both countries the rocks on which goitre occurs most frequently are both calcareous and metalliferous. Metalliferous impurities alone cannot be credited with the origin of the disease, or the Devonian and the granite would not be free from it. And the absence of chalk does not check the disease, or the ferruginous sands of the Weald would not support it.

Leprosy in China.

Leprosy exists among the Chinese to a greater extent than is generally supposed. It is one of the most dreaded of diseases in China. There is a current belief there, that if a person afflicted with it can kill a young girl and eat her heart, the evidences of the disease will not appear in the face, and that he can thus escape being known as a leper. This notion has probably been the cause of many murders. The leper's demand for alms is seldom refused, most Chinamen dreading the victim of this loathsome affection, and fearing that, if denied assistance, he may in some way infect them with his leprosy, as, for instance, by tainting their food.

Personal.

—Dr. R. B. S. Hargis has been appointed chairman of the Board of Health of Pensacola, Fla.

—There are thirty-nine doctors in the new French Chamber, and all of them but one are Republicans.

—The Board of Managers of the Presbyterian Hospital has unanimously elected Dr. H. Augustus Wilson as Pathologist of that institution, vice Dr. D. F. Willow, who was elected Surgeon to fill the vacancy caused by the death of the late H. Lenox Hodge, M.D.

—Mr. William MacCormac has received the honor of knighthood, in consideration of his services as honorary Secretary-general of the International Medical Congress. He was born in 1836. He is the son of an eminent physician, Dr. Henry MacCormac, of Belfast. Mr. MacCormac was a student in the Queen's University, Ireland,

and was elected surgeon to the Royal Hospital, Belfast, in 1864. In 1870, on the outbreak of the Franco-German war, Mr. MacCormac immediately volunteered his services, and was nominated by the French Minister of War, for duty in one of the hospitals of Metz. He was afterward appointed surgeon-in-chief of the Anglo American Ambulance, which, under his direction, both during the battle of Sedan and subsequently, was able to render signal services to the wounded of both nations. He embodied the results of his war experience in an interesting volume, entitled "Recollections of an Ambulance Surgeon," which was translated into German, French and Italian. On returning to England, Mr. MacCormac was elected to the Fellowship of the Royal College of Surgeons of England, and shortly afterwards, surgeon and lecturer on surgery to St Thomas's Hospital.

Items.

—A case of bulging brow: "What a fine, protuberant forehead your baby has, Mrs. Jones! Did he get it from his father?" "No," replied Mrs. Jones, "he got it from a fall down stairs."—*Boston Transcript.*

—A frightful epidemic of typhoid fever is now raging at Athens. Ten thousand persons, or a tenth of the whole population, have been attacked by it, and those who can, are flying from the city. The probable explanation of the outbreak is, some pollution of the Athens water, which is at all times of bad quality.

—"Just keep your bottle of whisky in your closet, and when the girl brings you your hot shaving water in the morning, you can mix your toddy quickly and not a soul will know a thing about it," said the M. D. The plan worked well until the old man's daughter thought he must be going insane, because he wanted to shave five or six times every day.—*Boston Transcript.*

—At the annual meeting of the Homœopathic Medical Society of the State of New York, held last month, Dr. H. M. Paine, of Albany, read a paper relating to the new law providing for the registration of plumbers and the legal supervision of all plumbing work in the cities of New York and Brooklyn. The law provides for the registration of all parties engaged in the business of plumbing. A violation of its provisions is made a misdemeanor. It requires all plumbing and draining work to be constructed in accordance with plans to be approved by the Boards of Health of these two cities respectively. By this means only can there be secured the requisite thoroughness, efficiency and uniformity of construction; hence the necessity and usefulness of the law.

—Tact is as necessary as knowledge to a successful practitioner. It is well known that Lord Eldon, when plain John Scott, eloped with the lady whom he married, and that they were lovers all their lives. While it was yet very early with them, young Mrs. Scott fell ill in a strange village, and the local practitioner was sent for. Having, after the usual routine, failed to make out what was the matter with this beautiful lady, he said: "I'm afraid, ma'am, there is something on your mind? You are not happy with your husband?" This was bad practice. Mrs. Scott had much spirit and natural eloquence, and there was nothing the matter with Mr. Scott, who was both tall and athletic; but the muse will not sing the dismissal of that doctor.—*London Spectator.*

QUERIES AND REPLIES.

Eczema.

If Dr. B. B. G., of Tenn., will try Muriate of Ammonia Pulvis for Eczema, five to ten grains in a wine-glass of water internally after each meal, and thirty to forty grains of the same dissolved in one-half pint of water externally to parts affected by bandage, saturated with the solution or frequent application without bandage, he will be content after the first week to persevere. In my experience three to six weeks' time has been required to effect a cure. R. O. CRANDALL, M.D.

Dr. J. B. R. P., of Del.—The laws regulating the practice of medicine in the city of Philadelphia may be obtained at the office of the Board of Health, 600 Sansom street.

Dr. W. H. J., of Pa.—We know nothing of the preparation "Selerina," to which you refer, and have on general principles great distrust of the efficacy of any secret remedy.

Dr. T. G. E., of W. Va., asks:—"What is the best vehicle for preserving nitrate of silver in solution for an indefinite time? Water throws down a precipitate after standing a certain time."

Dr. J. W. C., of Ala.—Reports the appearance of a large, fluctuating, pulsating, but painless tumor, commencing near the mastoid process and extending under the ear, on a child eleven months old, and asks a diagnosis. It is impossible to do more than guess at the nature of such a tumor, without personal examination. We would not venture a positive answer to such inquiries.

Experimenter, of Pa.—The International Congress of Electricians began in Paris, September 15th. We have seen no list of American Delegates.

Victor, of N. Y.—It is quite possible that the native Indians know an "infallible antidote" to the rattlesnake bite. But if they do, they have kept the secret well.

MARRIAGES.

MECKLEM—PARRY.—By the Rev. C. S. Ernsberger, Saturday evening, September 10th, 1881, at the residence of the bride's parents, W. S. Mecklem, M.D., and Alice U. Parry, all of Lucas, Ohio.

KLINK.—SCHMIEDT.—On September 14th, 1881, by the Rev. S. C. Breyfogel, Frederick Klinck, M.D., to Miss Minnie Schmiedt, all of this city.

FARNHAM—HUSSEY.—In Skowhegan, Maine, August 14th, by the Rev. O. J. Hancock, A. E. Farnham, M.D., and Miss Jennie K. Hussey, both of East Madison, Me.

DEATHS.

WILLS.—Died in Cecil Co., Md., August 9th, Anne Cox, aged one month; and on the 28th of the same month Zebulon Porter, aged two months and twenty days, infant children of Z. P. and Mary E. Lusby, and grandchildren of Dr. S. E. Wills.